

5444

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>43 Hanover Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Wallace</b> Last <b>Bartol</b>		4. DATE OF DEATH Month <b>5</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 - 16 - 73</b>
9. AGE (In years last birthday) yrs. <b>86</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insur. Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John D. Bartol</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis, with psych. reaction</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9 - 29 - 1958</b> , to <b>5 - 15 - 59</b> , that I last saw the deceased alive on <b>5 - 15 - 1959</b> , and that death occurred at <b>5:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital</b> <b>5 - 16 - 59</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 19 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur B. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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— 18 —

TABLE 1

1. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

100

Figure 1

## 5445 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural-Mt. Airy</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural--Mt. Airy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1 Harrisville</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>PEARL M. BAUMGARDNER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jacob Fritz</b>		14. MOTHER'S MAIDEN NAME <b>Lydia A. Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Ruby Norwood, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General Metastasis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>59</b> , to <b>May 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 3</b> , 19 <b>59</b> , and that death occurred at <b>1245 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. M. Waltz</b>		DATE SIGNED <b>5-4-59</b>	
PHYSICIAN'S NAME (Type) <b>C. M. Van Boele</b>		ADDRESS (Street, city or town, state) <b>Mt. Airy, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-6-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Airy, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	

## 5446 CERTIFICATE OF DEATH

Reg. Dist. No.

05435

1. PLACE OF DEATH a. COUNTY <b>Carroll - Rural, Sykesville, MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLYDE</b> Middle <b>HENRY</b> Last <b>BEACHLEY</b>		4. DATE OF DEATH Month <b>5</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/95</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin H. O. Beachley</b>		14. MOTHER'S MAIDEN NAME <b>Schildtknecht, Helen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 578-03-5225</b>	
17. INFORMANT <b>Record, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychotic depressive reaction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/30/59</b> , 19 <b>59</b> , to <b>5/11/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/10/59</b> , 19 <b>59</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gertrude M. Gross, M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Gertrude M. Gross, M.D.</b>		DATE SIGNED <b>5/12/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG242 5-11-59 et

5447

## CERTIFICATE OF DEATH

Reg. Dist. No.

05436

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>9 m 2 d</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Baltimore 2, Md. 18</b>		3. DATE OF DEATH <b>5 3 1959</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>John</b> Last <b>Berkley</b>		4. DATE OF DEATH Month <b>5</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 11, 1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>3</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland, BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Berkley</b>		14. MOTHER'S MAIDEN NAME <b>Minerva MARY L. HEIM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unkn</b>	
INFORMANT <b>MR. CHARLES F. BERKLEY</b> <b>(S.S. Hospital Records) 1405 N. GATE ROAD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>3-6-1958</b> to <b>5-2-1959</b> , that I last saw the deceased alive on <b>5-2-1959</b> , and that death occurred at <b>3:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5-3-59</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. <b>Springfield State Hospital</b> PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> <b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 6, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTO. MARYLAND</b>		24a. REC'D BY REGISTRAR <b>MAY 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. K...</b>			

800 00

STATE OF TEXAS

1911

1911

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05437

5448

1. PLACE OF DEATH a. COUNTY <u>Sanoll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Sanoll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
c. LENGTH OF STAY IN 1b <u>30 yrs</u>		d. STREET ADDRESS <u>1 N Boring - Hampstead Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SERANDA - A - BORING</u>		4. DATE OF DEATH <u>May 16 1959</u>	
5. SEX <u>TH</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16 - 1875</u>
9. AGE (In years last birthday) <u>84 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Huck</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi Leuer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>1 N Boring - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) 20 years INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19 35</u> to <u>May 16 1959</u> , that I last saw the deceased alive on <u>May 15, 1959</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		<u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>May 19 - 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	22d. LOCATION (City, town, or county) (State) <u>Sanoll Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Lipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-1-18

Blank certificate form with horizontal lines for text entry.

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5449 CERTIFICATE OF DEATH

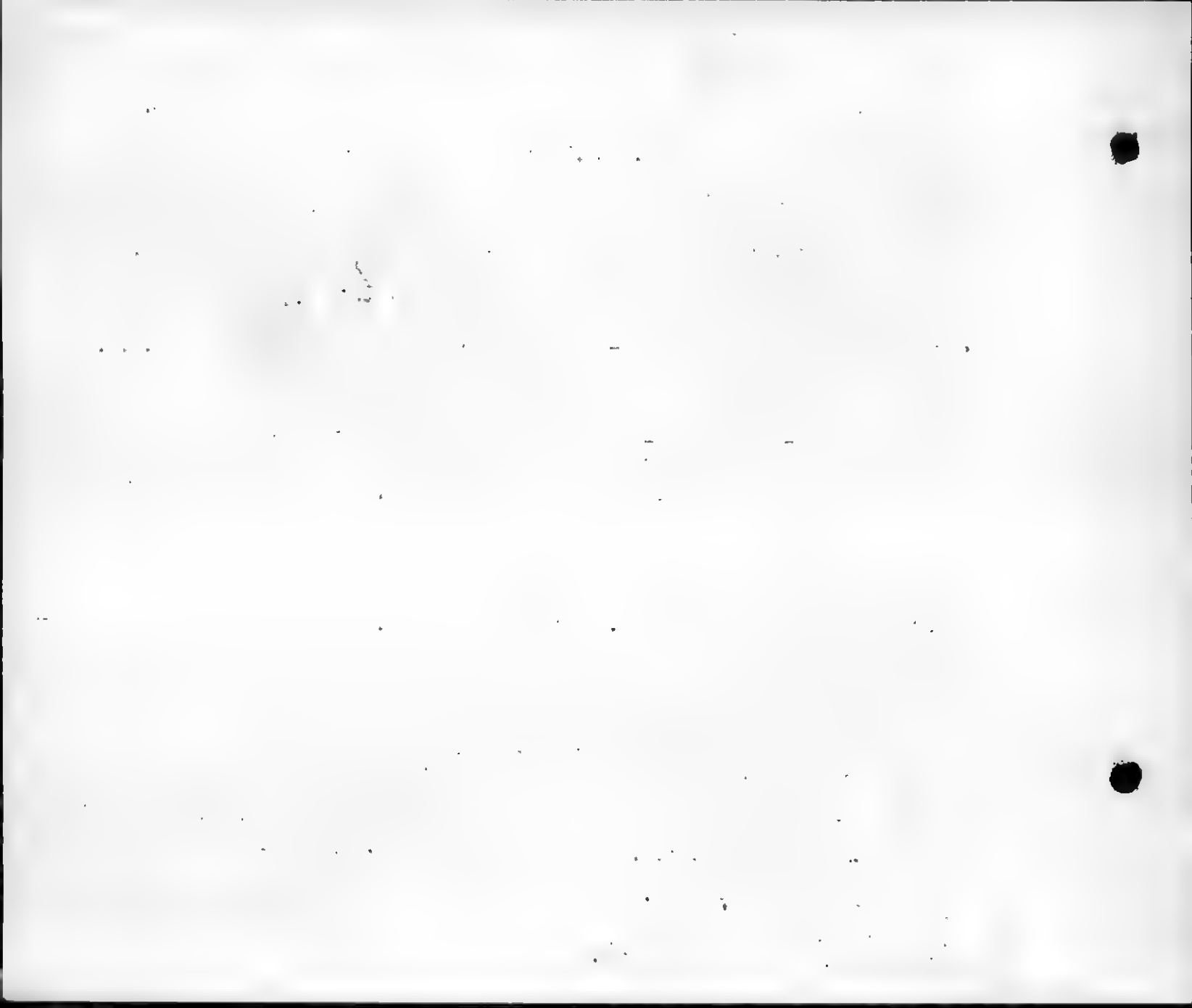
Reg. Dist. No.

05438

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>32yrs.6mos.10days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1153 Hamburg Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lottie</b> Middle <b>Byron</b> Last <b>Bosley</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 10, 1895</b>
9. AGE (In years (or birthday) yrs <b>63</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Byron</b>		14. MOTHER'S MAIDEN NAME <b>Florice Cline</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> <b>4:20.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Epilepsy with mental deficiency. Bronchopneumonia.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>October 20, 1954</b> , to <b>May 6, 1959</b> , that I last saw the deceased alive on <b>May 6, 1959</b> , and that death occurred at <b>8:50AM</b> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		DATE SIGNED <b>5/6/59</b>
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9/59</b>
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Toppel</b> ADDRESS <b>5311 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>MAY 8 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

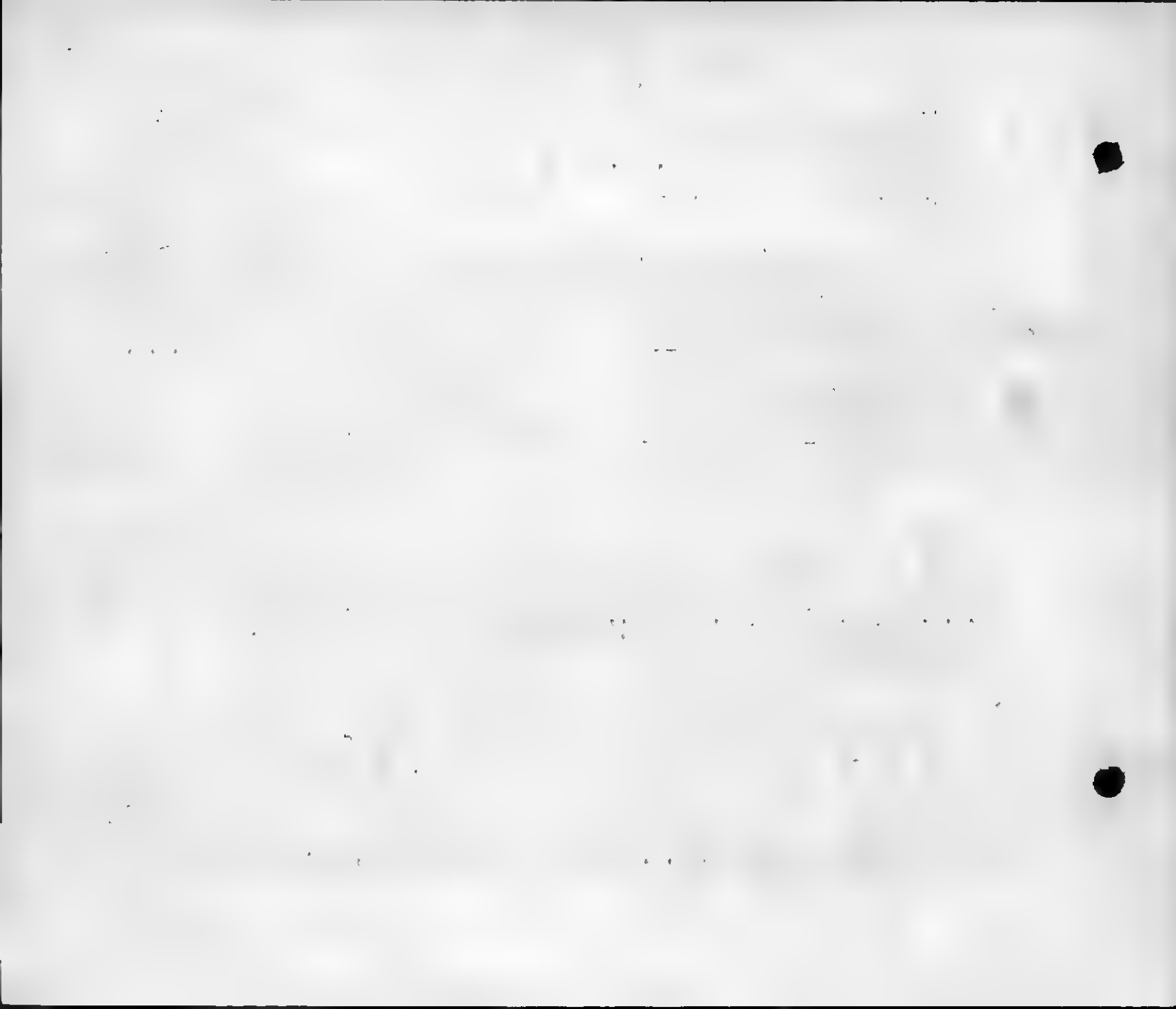
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5450 CERTIFICATE OF DEATH

Reg. Dist. No.

05439

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4y. 6mo. 20days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Jane</b> Last <b>Burney</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1867</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McElhinney</b>				14. MOTHER'S MAIDEN NAME <b>Emma Birchall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				17. INFORMANT <b>Springfield Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>G.B.S. assoc. with dist. of met., growth or nutrition with senile brain disease with psychotic reaction, fracture, neck of right femur.</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>October 29, 1954</b> , to <b>May 18, 1959</b> , that I last saw the deceased alive on <b>May 18, 1959</b> , and that death occurred at <b>10:00pm</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital 5/19/59</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. FURNER'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5/20/59</b>		22b. DATE THEREOF <b>5/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Re: Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>300-4th St N.E. Wash D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John See 9 Son</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	





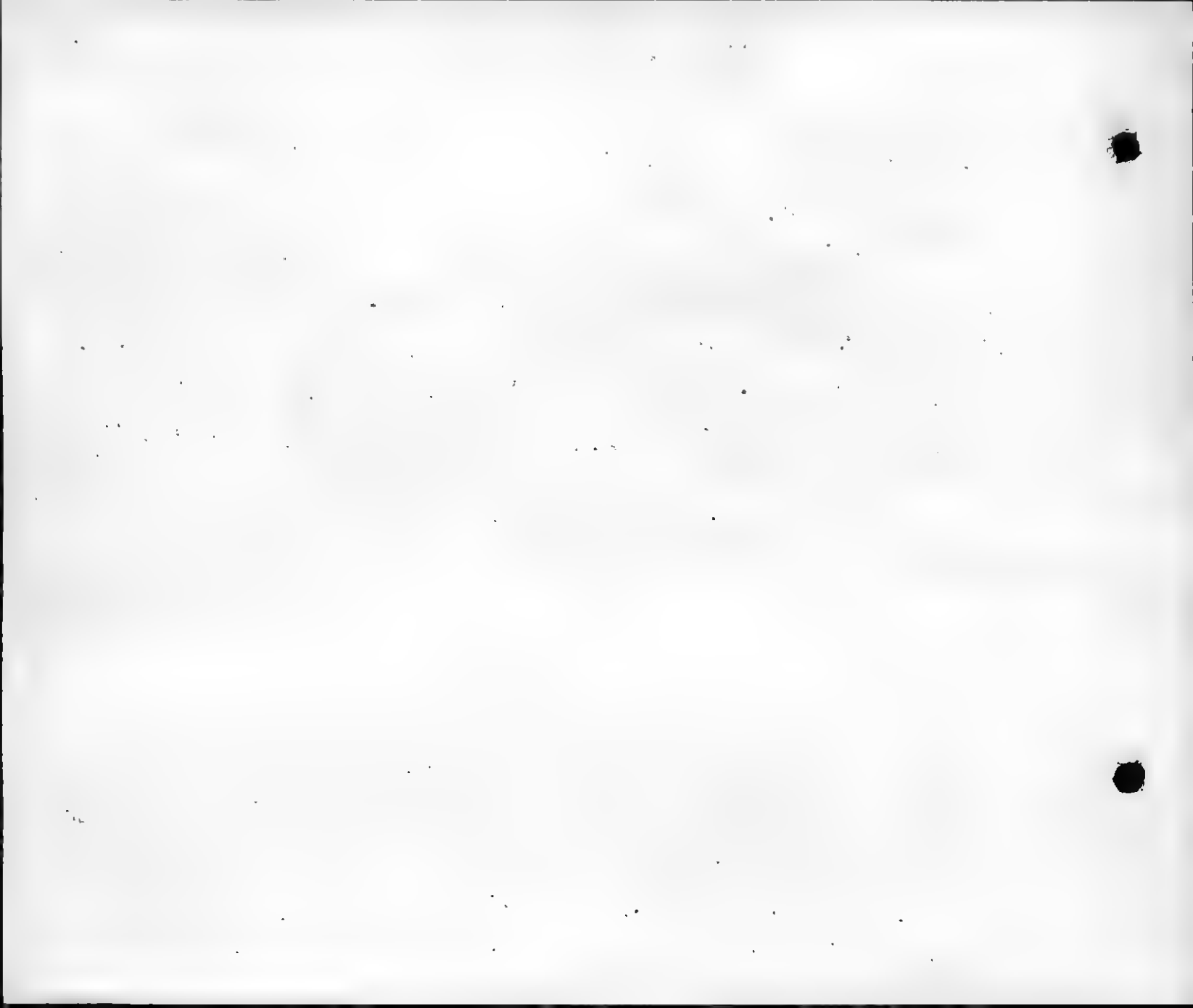
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5451 CERTIFICATE OF DEATH

Reg. Dist. No. 05440

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berrett</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berrett</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Linger Boarding Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur C. Connell</u>				4. DATE OF DEATH Month Day Year <u>May 21 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 25, 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lead Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R. R.</u>			
13. FATHER'S NAME <u>Perry H. Connell</u>				14. MOTHER'S MAIDEN NAME <u>Mollie C. Higgins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>718-18-0263A</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General debility - progressive</u> DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1 many years</u> (b) <u>Diabetes</u> DUE TO <u>1 many years</u> (c) <u>Diabetes</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 many years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.) <u>No accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>X 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>				20f. (City or town) (County) (State) <u>X</u>			
21. I certify that I attended the deceased from <u>Jan 1958</u> to <u>May 20 1959</u> that I last saw the deceased alive on <u>5-20</u> , 1959, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. C. Stone</u> M.D. <u>N. C. Stone</u> <u>md</u>				DATE SIGNED <u>md</u>			
PHYSICIAN'S NAME (Type) <u>N. C. Stone M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Moriah</u>		22d. LOCATION (City, town, or county) (State) <u>Phila. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hight</u> ADDRESS <u>Stykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hight</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5452 CERTIFICATE OF DEATH

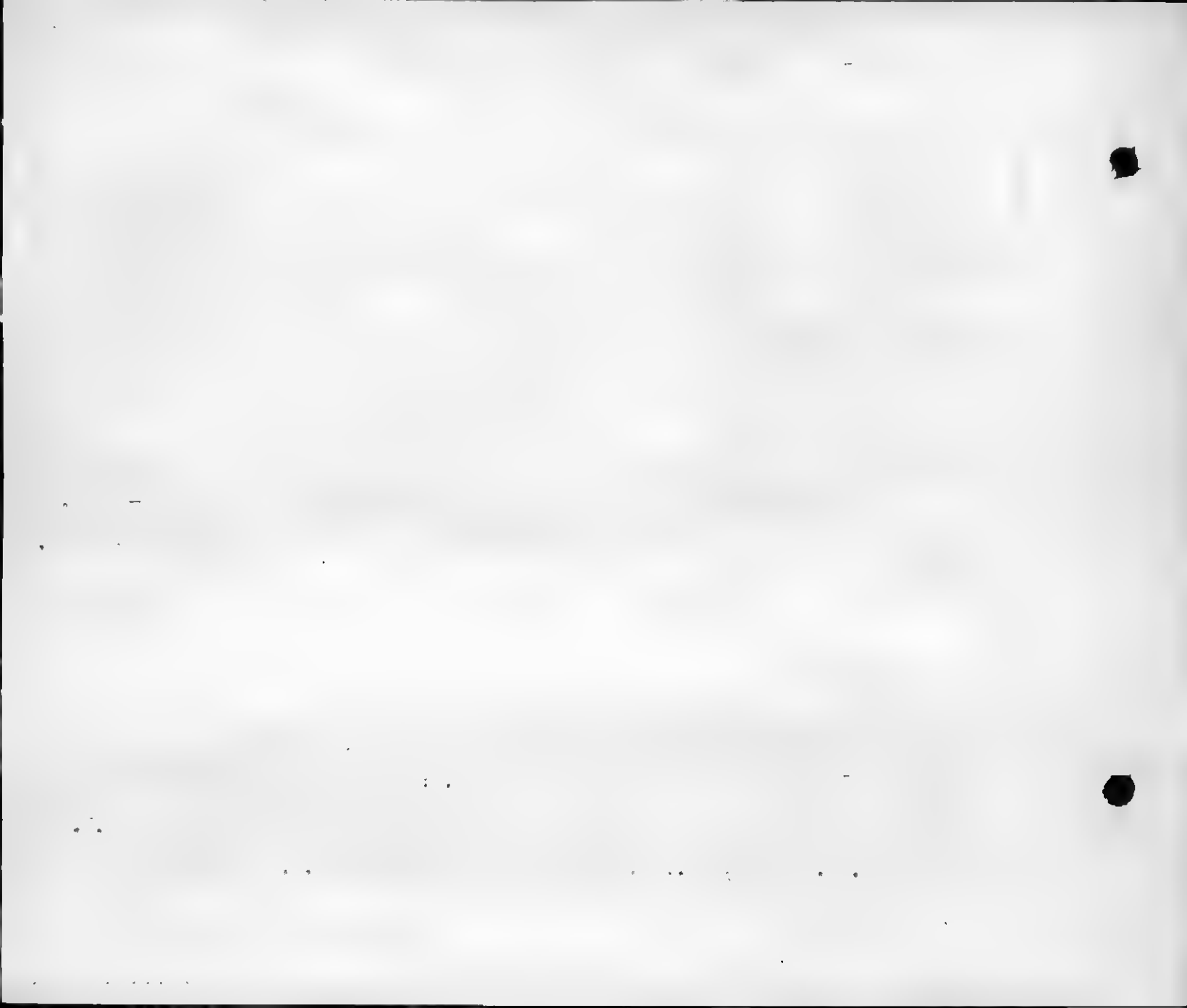
05441

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cornell</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cornell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OR INSTITUTION</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Philip J. DIETRICH</u>		4. DATE OF DEATH <u>May 1 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14-1879</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Fireman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Philip J. Dietrich</u>	
14. MOTHER'S MAIDEN NAME <u>Nannie Hyatt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-09-0199</u>		17. INFORMANT <u>Mrs. Sadie Dietrich Sykesville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LIVER, TYPE AND PRIMARY SITE UNKNOWN</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>SENILITY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-6 mos.</u> <u>15-20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 9 1959</u> to <u>April 1 1959</u> , that I last saw the deceased alive on <u>April 1 1959</u> , and that death occurred at <u>10:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>5.1.59</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		<u>Sykesville P.O., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	22d. LOCATION (City, town, or county) (State) <u>Cornell Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Tipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>MAY 4 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Tipton</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5453

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05442

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>6 yrs 9 mos 25 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. STREET ADDRESS <u>5500 Fernpark Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eileen Josephine Dore</u>		4. DATE OF DEATH Month Day Year <u>May 23 1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1910</u>
9. AGE (In years last birthday) <u>48 yrs.</u>		10. IF UNDER 1 YEAR Months Days <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James F. Dore</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ganey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>* None</u>	
17. INFORMANT <u>Springfield State Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Post encephalitic Parkinson's disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2m</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>		ADDRESS <u>4600 Liberty Hgts. Ave.</u>	
24a. REC'D BY REGISTRAR <u>May 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christine S. K...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





17  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

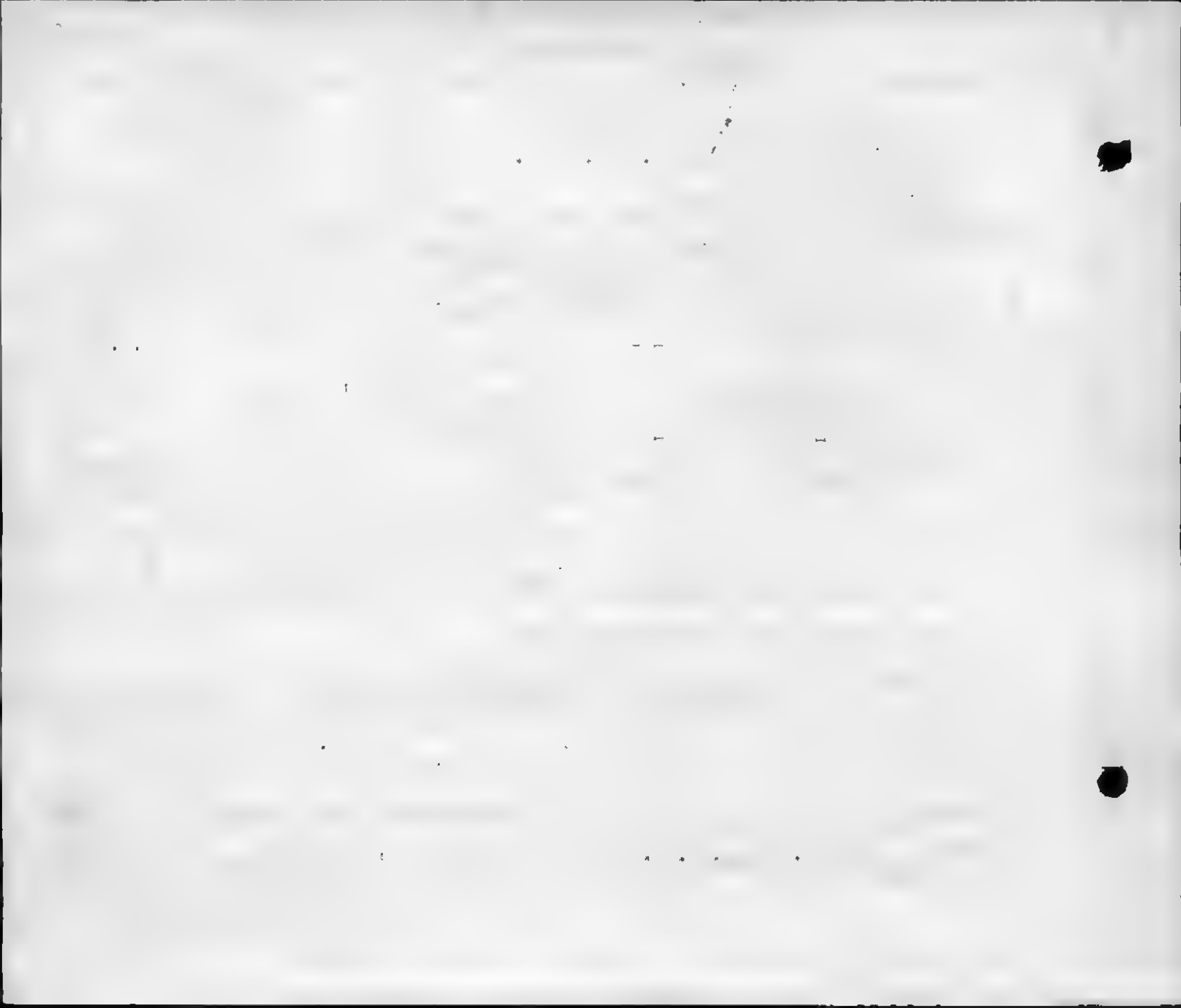
5454 CERTIFICATE OF DEATH

Reg. Dist. No.

05443

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>20 y. 6 m. 23</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Josephine Schwartz Drummey</b>		4. DATE OF DEATH Month Day Year <b>May 10 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>George Schwartz</b>		14. MOTHER'S MAIDEN NAME <b>Hanore O'Shantessy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT Address <b>Springfield State Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pericardial Tamponade</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Myocardial infarction and rupture</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paranoid reaction, paranoid state</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1957</b> , to <b>May 10, 1959</b> , that I last saw the deceased alive on <b>May 10, 1959</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>5/10/59</b>	
ACTUAL SIGNATURE <b>Rita S. Glahn</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Rita S. Glahn, M. D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>5/13/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry A. Crummett</b> ADDRESS <b>4204 Ridgemoor Rd</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

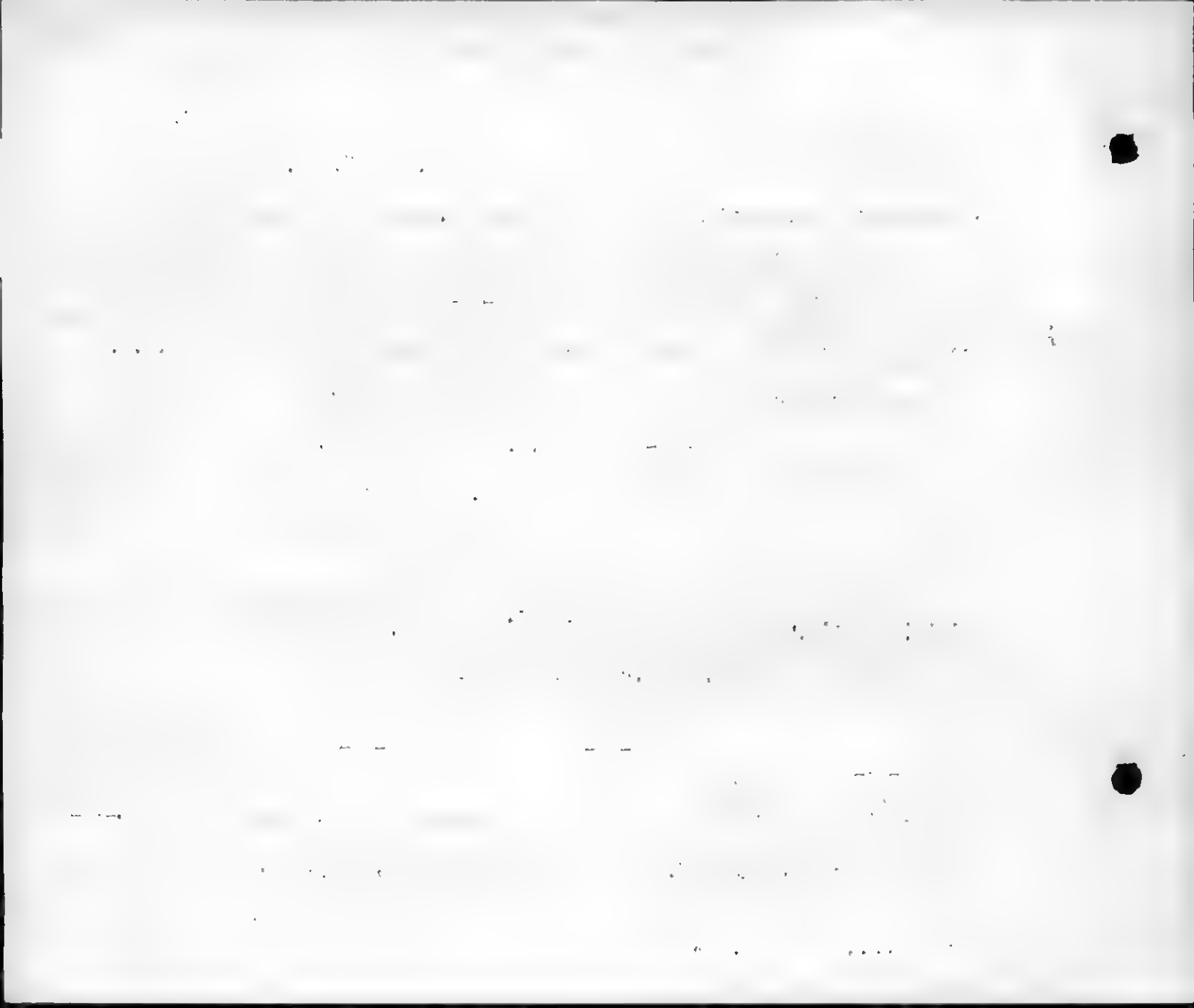
## 5455 CERTIFICATE OF DEATH

05444

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Carroll</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">City</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Sykesville</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">9 m 23 d</span>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Baltimore 18, Md.</span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="font-size: 1.2em;">Springfield State Hospital</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">1825 N. Montford Avenue</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Martin</span>		First <span style="font-size: 1.2em;">John</span> Middle <span style="font-size: 1.2em;">Engelhardt</span> Last		<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">5</span> Day <span style="font-size: 1.2em;">16</span> Year <span style="font-size: 1.2em;">19 59</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. COLOR OR RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10-15-77</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">81</span> yrs.	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Foreman (ret'd)</span>		10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">United Oil Co.</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">George Engelhardt</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Margaret Meyers</span>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-09-0901</span>	INFORMANT <span style="font-size: 1.2em;">S.S. Hospital Records</span>		Address		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Arteriosclerotic cardiovascular disease</span> DUE TO (b) <span style="font-size: 1.2em;">444.1</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">years</span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="font-size: 1.2em;">C.B.S. assoc. with cerebral arteriosclerotic or senile brain disease, with psych. reaction. Fracture of neck of the left femur.</span>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <span style="font-size: 1.2em;">no history of accident Med. Exam. released the body</span>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <span style="font-size: 1.2em;">19</span>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <span style="font-size: 1.2em;">7-23-</span> 19 <span style="font-size: 1.2em;">59</span> , to <span style="font-size: 1.2em;">5-16-</span> 19 <span style="font-size: 1.2em;">59</span> , that I lost saw the deceased alive on <span style="font-size: 1.2em;">5-16-</span> 19 <span style="font-size: 1.2em;">59</span> , and that death occurred at <span style="font-size: 1.2em;">10:20 A.M.</span> , from the causes and on the date stated above							
ACTUAL SIGNATURE <span style="font-size: 1.2em;">Edmund Lusthaus</span>		M.D. <span style="font-size: 1.2em;">Springfield State Hospital</span>		DATE SIGNED <span style="font-size: 1.2em;">5-16-59</span>			
PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Edmund Lusthaus M.D.</span> <span style="float: right;">Sykesville, Maryland.</span>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		22b. DATE THEREOF <span style="font-size: 1.2em;">5-20-59</span>	22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>		22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore</span>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <span style="font-size: 1.2em;">Wm. Cook, Inc., 1217 St. Paul Street</span>				24a. REC'D BY REGISTRAR DATE <span style="font-size: 1.2em;">MAY 20 '59</span>		24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Arthur L. House</span>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5456

## CERTIFICATE OF DEATH

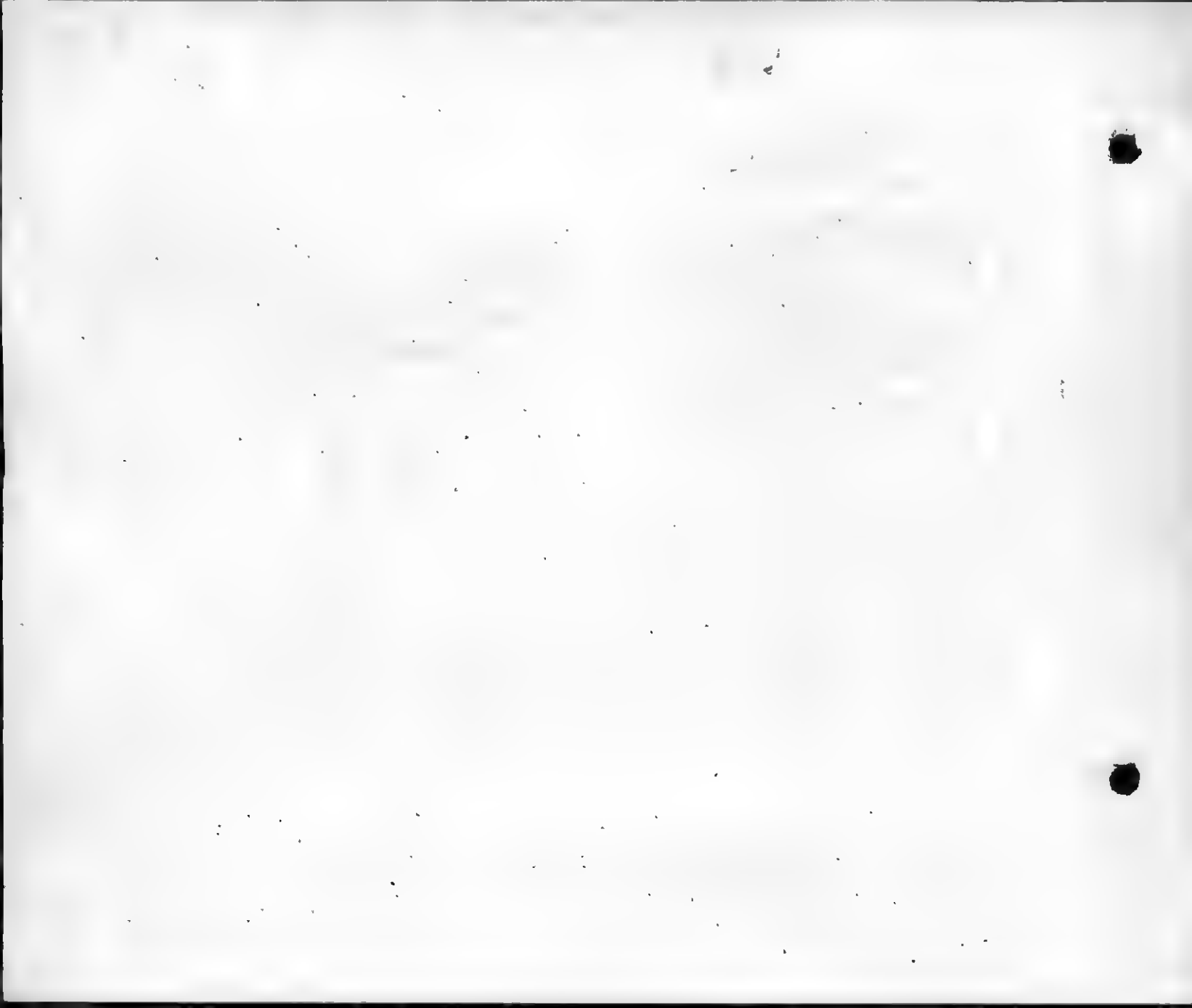
05445

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <u>Id</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allesia</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry A. Eppley</u>		4. DATE OF DEATH <u>May 29 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/1881</u>
9. AGE (In years last birthday) <u>77</u>		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>7</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Dellinger</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Wilhelm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Charles Eppley Allesia Md</u>		Address <u>Allesia Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>400.0</u> DUE TO <u>Arteriosclerotic Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart</u> DUE TO <u>Arteriosclerotic Heart</u> (c) <u>Arteriosclerotic Heart</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)	
21. I certify that I attended the deceased from <u>March 7, 1954</u> , to <u>May 29, 1959</u> , that I last saw the deceased alive on <u>May 29, 1959</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.H. Feagles</u> M.D.		ADDRESS (Street, city or town, state) <u>Allesia Md</u> DATE SIGNED <u>5/29/59</u>	
PHYSICIAN'S NAME (Type) <u>W.H. Feagles</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>5/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>	
22d. LOCATION (City, town, or county) (State) <u>Carroll Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Buckner</u>	
24a. REC'D BY REGISTRAR <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





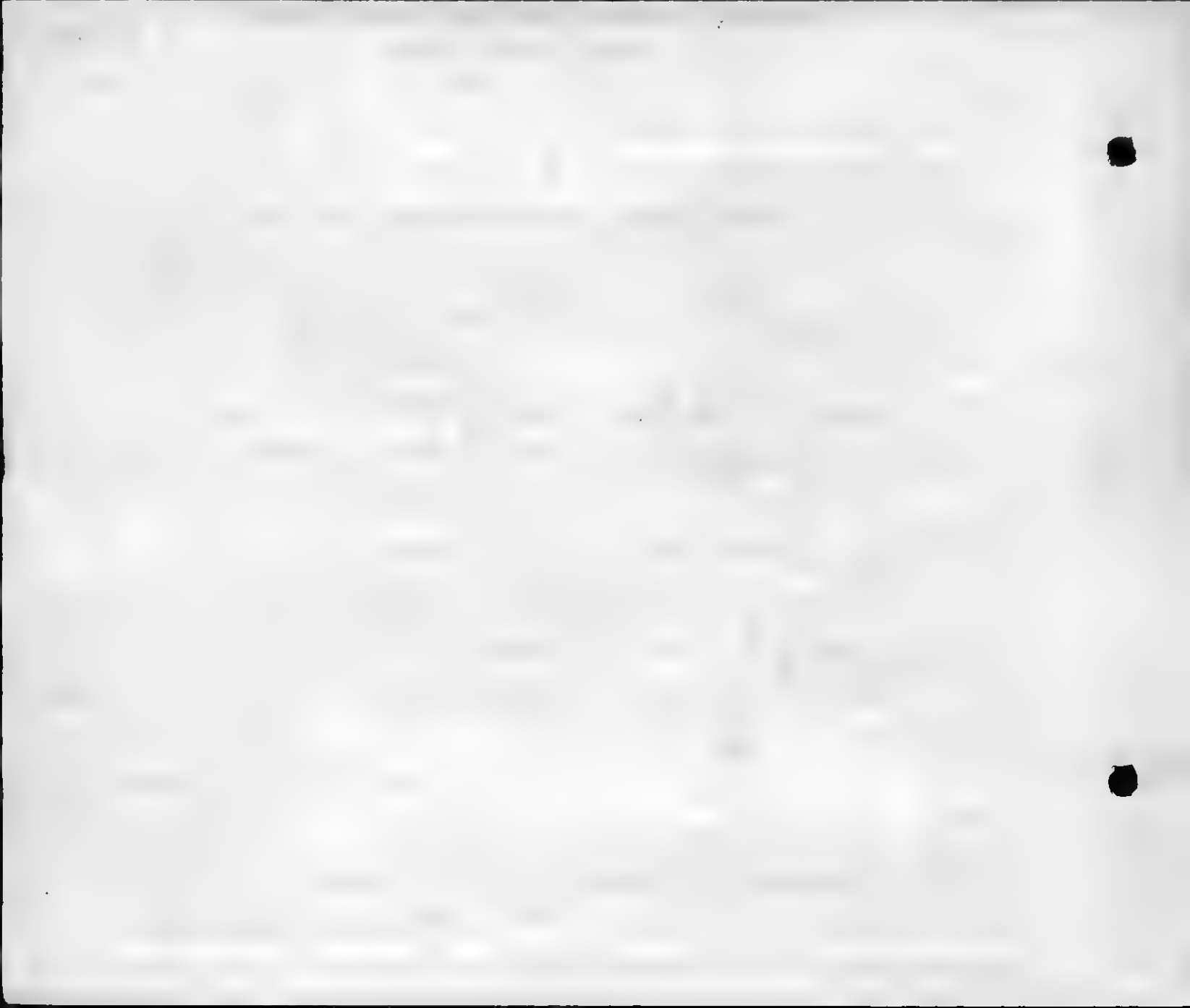
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5457 CERTIFICATE OF DEATH

05446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Rockingham</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carroll Westminister</u>				c. LENGTH OF STAY IN 1b <u>11 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisonburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daughters home</u>				d. STREET ADDRESS <u>1357 S. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES MICHAEL FRANK</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 9 1866</u>	
9. AGE (In years, last birthday) <u>93</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Rockingham Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME <u>Jacob James Frank</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Beery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. T.B. Padg, Westminister, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis General</u> DUE TO (c) <u>General</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 5, 1957</u> , to <u>May 23</u> , 1959, that I last saw the deceased alive on <u>May 22</u> , 1959, and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wiglema Speicher</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminister Md</u>			
PHYSICIAN'S NAME (Type) <u>Wiglema Speicher</u>				DATE SIGNED <u>5/23/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 23, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cooks Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockingham Co. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Myers Jr.</u>				ADDRESS <u>Westminister, Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>MAY 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5458

## CERTIFICATE OF DEATH

05447

Reg. Dist. No.

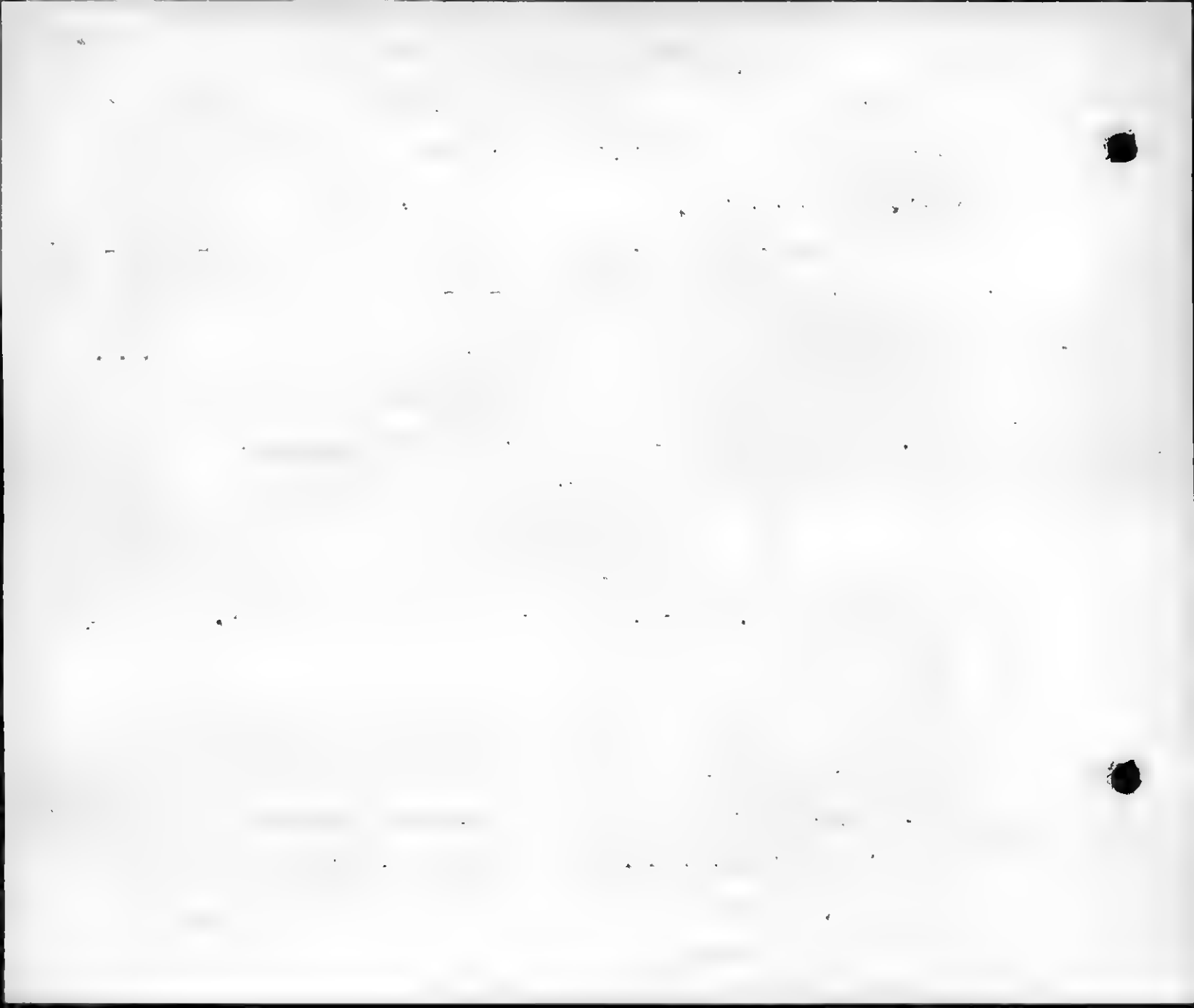
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>11yrs. 4mos. 23days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Groom Station</b>	
f. STREET ADDRESS <b>-</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Horace</b> Last <b>Garner, Jr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 31, 1909</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>50</b> Days <b>27</b> Hours <b>23</b> Min.	11. IF UNDER 24 HRS Hours <b>23</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward H. Garner</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Duley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
INFORMANT <b>Springfield Hospital Records</b>		Address <b>-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491X. IMMEDIATE CAUSE (a) Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsonian syndrome without psychosis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 7, 1959</b> to <b>May 27, 1959</b> , that I last saw the deceased alive on <b>May 26, 1959</b> , and that death occurred at <b>4:55A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5/27/59</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		DATE SIGNED <b>5/27/59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Groom Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>		24. BY REGISTRAR <b>John B. 59</b>	
ADDRESS <b>Ritchie Bros. Upper Marlboro, Md.</b>		25. REGISTRAR'S SIGNATURE <b>John B. 59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <span style="float: right;"><b>MARYLAND</b></span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b> <b>03</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>38 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		e. STREET ADDRESS <b>2745 Dungen Court</b>	
<b>3. NAME OF DECEASED</b> (Type or print)		<b>4. DATE OF BIRTH</b>	
First <b>Raymond</b> Middle <b>Charles</b> Last <b>Gately</b>		Month <b>5</b> Day <b>24</b> Year <b>1959</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7-25 -1896</b>
<b>9. AGE</b> (In years last birthday) <b>62</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	<b>11. IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Steel worker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>	
<b>13. FATHER'S NAME</b> <b>William Gately</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Lena Freda</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes-Cpl. 6/1916 to 6/1919</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-</b>	
<b>INFORMANT</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bile peritonitis</b> <b>584X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ruptured gall bladder</b> DUE TO (c) <b>Gall stones</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Days</b> <b>Days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychotic depression. Carcinoma of the rectum operated on in 1955.</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>0</b> m. <b>19</b> p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from April 16, 1959, to May 24, 1959, that I last saw the deceased alive on May 24, 1959, and that death occurred at 4:40 P.M., from the causes and on the date stated above.</b>			
<b>ACTUAL SIGNATURE</b> <i>Agustin del Campo</i>		<b>DATE SIGNED</b> <b>5/25/59</b>	
<b>PHYSICIAN'S NAME (Type)</b> <b>Agustin del Campo, M.D.</b>		<b>ADDRESS (Street, city or town, state)</b> <b>Springfield Hospital</b> <b>Sykesville, Maryland</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>May 29, 1959</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>	<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore, Md.</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ullrich Funeral Home Dundalk, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAY 28 '59</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Hume</i>			

VS A15 (4)  
15M 9/5B





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5460 CERTIFICATE OF DEATH

Reg. Dist. No.

05449

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Long View Nursing Home</u>		d. STREET ADDRESS <u>Emory Road</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>A</u> Middle <u>Giles</u> Last		4. DATE OF DEATH <u>May</u> Month <u>25</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Kelly</u>	
14. MOTHER'S MAIDEN NAME <u>Sophia V. Eaton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>215-32-0605</u>		17. INFORMANT <u>Mrs George Henry</u> Address <u>Upperco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Atherosclerotic Cardio Vascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 15</u> , 19 <u>58</u> , to <u>May 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>59</u> , and that death occurred at <u>10145A</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>5/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) <u>Pikesville</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline &amp; Sons</u> ADDRESS <u>Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5461

## CERTIFICATE OF DEATH

Reg. Dist. No.

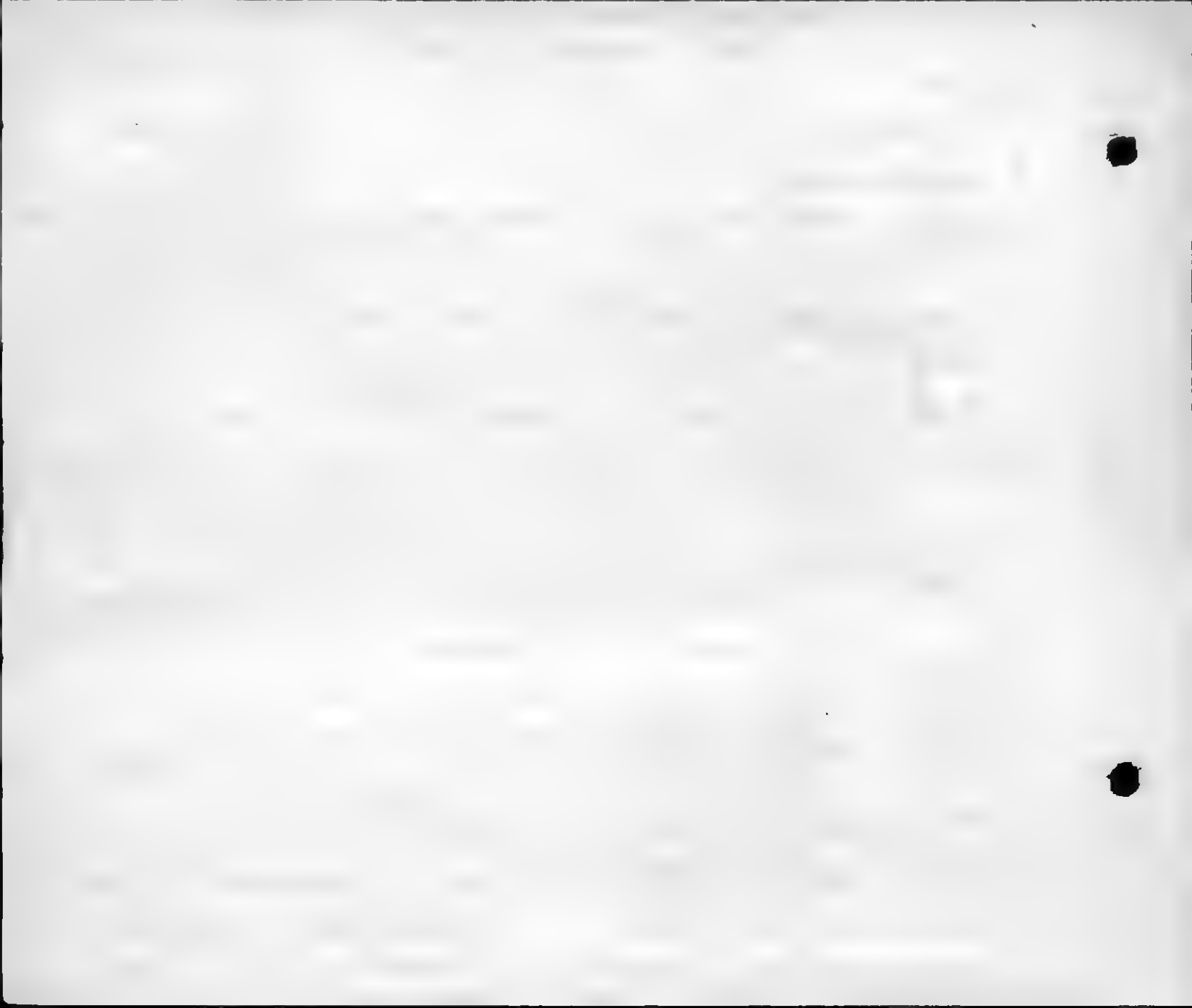
05450

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
c. LENGTH OF STAY IN 1b <u>7 months</u>		d. STREET ADDRESS <u>161 W. Green St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>61 W. Green St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>MAH</u> Last <u>GIST</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer Pa</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Evan M. Bush</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ruth Royer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. J. La Motte Smith, Westminster Md</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular accident</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1958</u> to <u>May 6, 1959</u> , that I last saw the deceased alive on <u>May 6, 1959</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Julius Chepko</u> M.D.		ADDRESS (Street, city or town, state) <u>85 W. Green St Westminster Md</u>	
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>		DATE SIGNED <u>5/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>May 9, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>First family Cemetery Westminster Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster Md</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	
DATE <u>MAY 11 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Carroll

Westminster

YES ☐ NO ☒

Year

IF UNDER 24 HRS.	
Hours	Min.

12. CITIZEN OF WHAT COUNTRY?  
U S A

Susan A. Ziegler

Springfield Hospital Records

INTERVAL BETWEEN  
ONSET AND DEATH  
Years

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)  
C.B.S.assoc.with convulsive disorder without qualifying phrase.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20f. (City or town)

(Continued)

(Stole)

21. I certify that I attended the deceased from August 2, 1957, to May 17, 1959, that I last saw the deceased alive on May 17, 1959, and that death occurred at 10:25PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Edmund Lustig, M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 5/18/59

PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.

Sykesville, Maryland

22d LOCATION (City, town, or county)

(5101\*)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

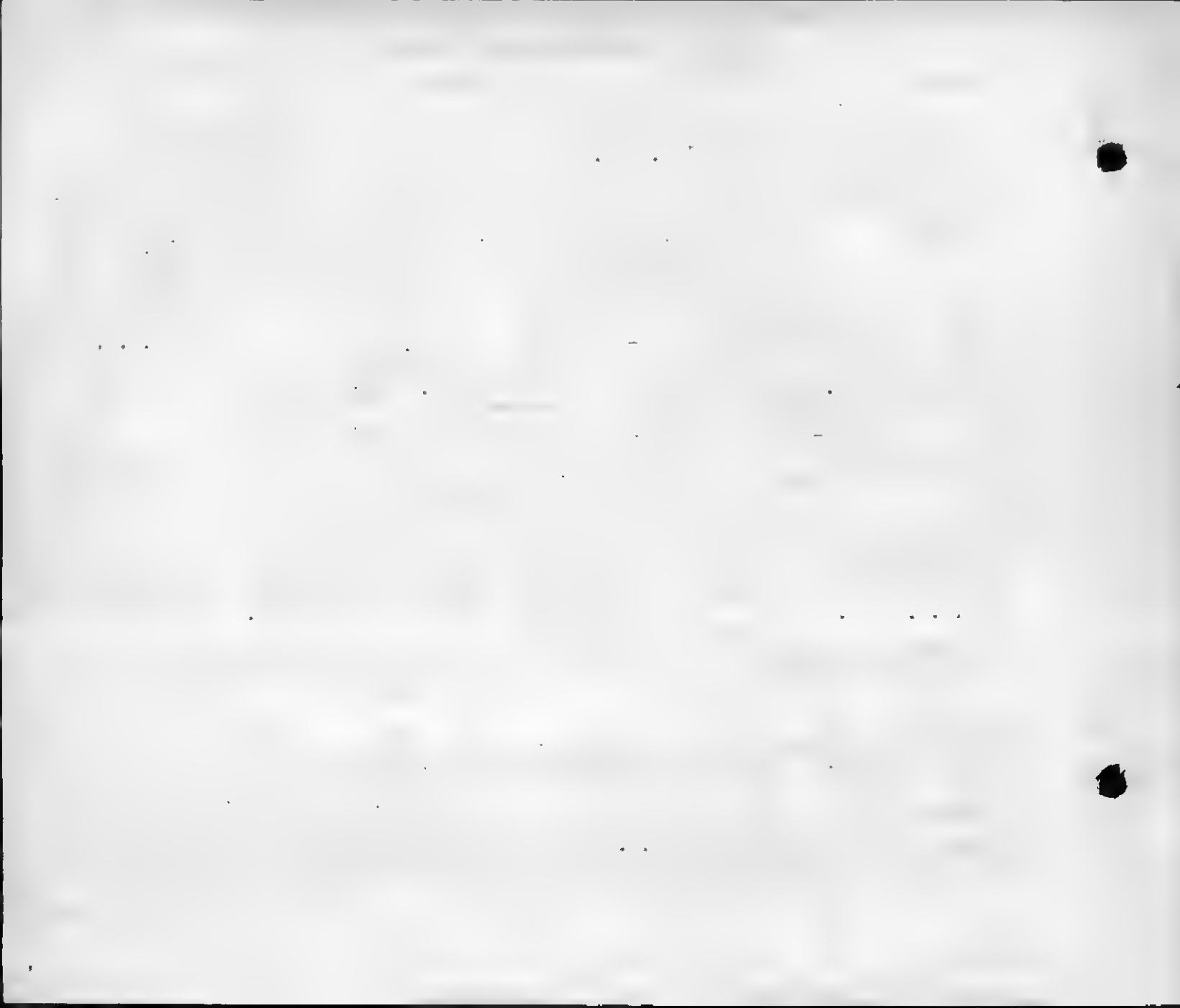
DATE MAY 19 '59

Arthur S. Frank

VS A15 (4)  
15M 9/55

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5463 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reese</b>	c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reese</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caples Convalescent Home</b>		d. STREET ADDRESS <b>R. 4 Westminster</b>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Stephenson</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1876</b>
9. AGE (In years and birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>16</b> Hours <b>19</b> Min. <b>59</b>	IF UNDER 24 HRS. Months <b>3</b> Days <b>16</b> Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Joshua Stephenson</b>	
14. MOTHER'S MAIDEN NAME <b>Emily Sabina Haas</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Stuart Green R. 4 Westminster, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c) <b>J</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>about May 1, 1954</b> , to <b>May 16, 1959</b> , that I last saw the deceased alive on <b>May 15, 1959</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. L. Billingslea</b> M.D.		ADDRESS (Street, city or town, state) <b>Westminster, Md.</b> DATE SIGNED <b>5-18-59</b>	
PHYSICIAN'S NAME (Type) <b>C. L. Billingslea, M.D.</b>		<b>1 S. Center St. Westminster, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>5-19-1959</b>	<b>St. John's Catholic</b>	<b>Westminster, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAY 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles A. Kirsch</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05453

Reg. Dist. No.

5464

FOR STATE  
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>GREENMOUNT</u> c. LENGTH OF STAY IN lb <u>MINUTES</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2 USUAL RESIDENCE (Where deceased lived If institul on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u> <u>RURAL</u> d. STREET ADDRESS <u>MILLERS STATION ROAD</u> e. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARL ULYSSES GREENWOOD</u> First Middle Last 4. DATE OF DEATH <u>MAY 30 1959</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 13-1928</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>31</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>EXCAVATING</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HORACE GREENWOOD</u> 14. MOTHER'S MAIDEN NAME <u>LOUISE HAINES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO <u>361-441349</u> 17. INFORMANT <u>HORACE GREENWOOD</u> Address <u>NEW WINDSOR MD</u> RURAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury - Puncture wound chest</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Automobile accident</u> 20c. TIME OF INJURY Month. Day. Year <u>2:30 p.m. 5-30 1959</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 30</u> 20f. (City or town) <u>Stamington</u> (County) <u>Carroll</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>James T. Marsh</u> EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>6/1/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD</u> 22d. LOCATION (City, town, or county) <u>NEW WINDSOR</u> (State) <u>MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler &amp; Sons New Windsor</u> ADDRESS <u>New Windsor</u> 24a. REC'D BY REGISTRAR <u>JUN 2 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Carlson &amp; Hearn</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



5465

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. LENGTH OF STAY IN 1b <u>25 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENEDUM ST.</u>				d. STREET ADDRESS <u>BENEDUM ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID GRANT HANN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/1872</u>		9. AGE (In years last birthday) <u>87</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FINISHING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELI HANN</u>				14. MOTHER'S MAIDEN NAME <u>DEBORAH STEM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>MRS WILBUR FOWBLE UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General debility</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>5-3-</u> , 19 <u>59</u> , to <u>5-7-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-7-</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D. <u>Union Bridge</u>				DATE SIGNED <u>5-7-59</u>			
PHYSICIAN'S NAME (Type) <u>T. H. WEGG M.D.</u>				<u>UNION BRIDGE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/10/59</u>		<u>MT VIEW CEM.</u>		<u>UNION BRIDGE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartley</u>				ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5466

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN TB <i>10 1/2 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>✓</i>		d. STREET ADDRESS <i>Manchester</i>	
3. NAME OF DECEASED (Type or print) <i>WILLIAM - E - HARE</i>		4. DATE OF DEATH Month <i>May</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 14-1890</i>
9. AGE (In years, last birthday) <i>69</i> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>✓</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John T Hare</i>		14. MOTHER'S MAIDEN NAME <i>Martha Baublitz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-10-5697</i>	
17. INFORMANT <i>Mrs Edna Hare</i>		Address <i>Manchester Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis of the heart</i> DUE TO (c) <i>hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14.2</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <i>hypertension</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 3</i> , 19 <i>57</i> , to <i>May 4</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>May 3</i> , 19 <i>57</i> , and that death occurred on <i>May 4</i> , 19 <i>59</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W H F</i>		ADDRESS (Street, city or town, state) <i>117 E. ...</i>	
PHYSICIAN'S NAME (Type) <i>W H F</i>		DATE SIGNED <i>5/1/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>May 8/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Grave Run</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E Tipton</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5467

## CERTIFICATE OF DEATH

05456

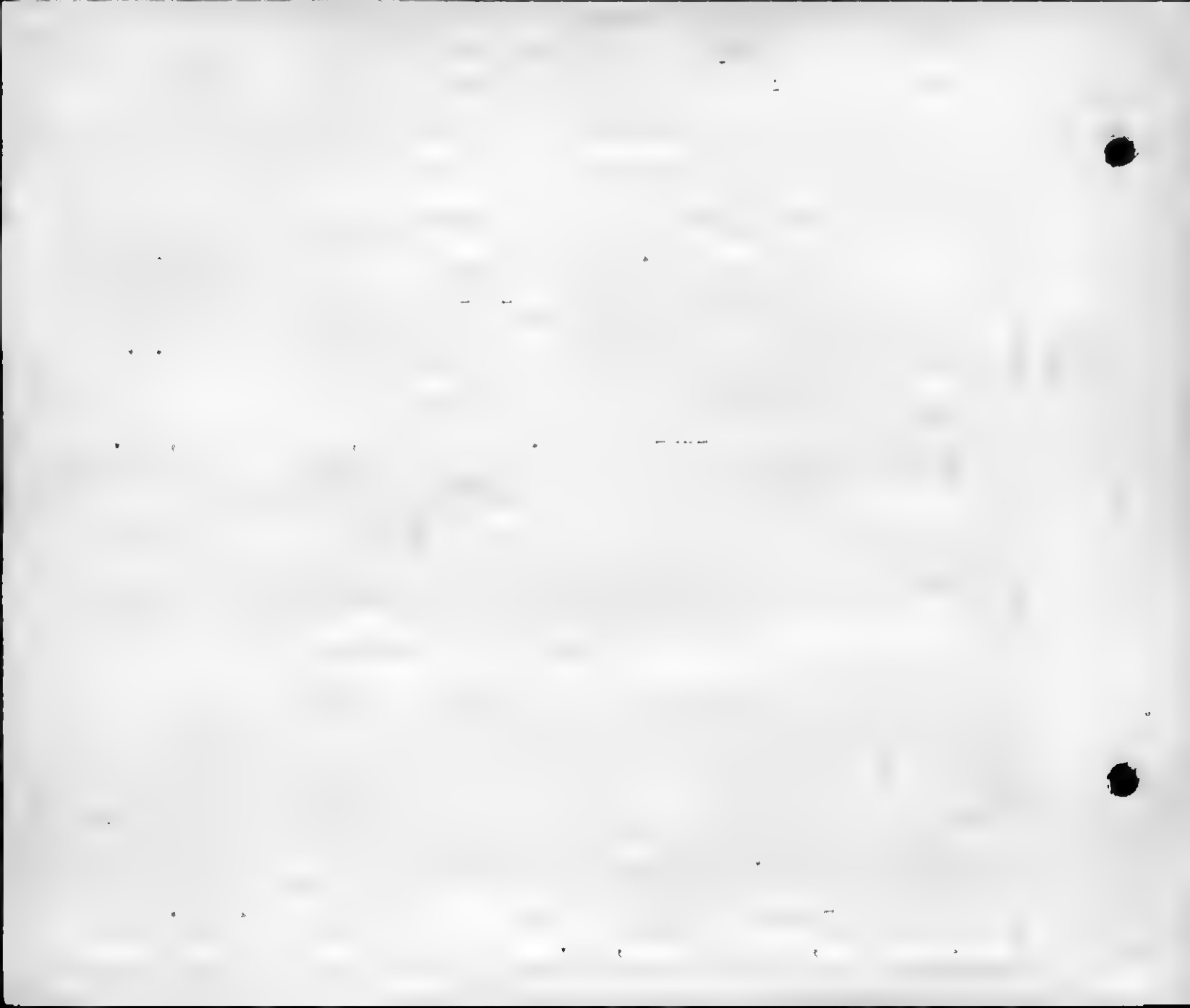
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pullen Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>N.</b> Last <b>HAUGH</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John Haugh</b>	
14. MOTHER'S MAIDEN NAME <b>Mary ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Mr. Edwin Haugh, Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, arteriosclerosis</b> DUE TO <b>generalized, hyper tension,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic brain syndrome, blood vessel disease</b> DUE TO (c) <b>1955</b> TO <b>19 May 59</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1955</b> TO <b>19 May 59</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Sykesville, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>1955</b> , 19____, to <b>19 May 1959</b> , that I last saw the deceased alive on <b>19 May 1959</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard E. Hall</b>		DATE SIGNED <b>19 May 59</b>	
PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL</b>		ADDRESS (Street, city or town, state) <b>Sykesville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5-22-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll CO., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be provided for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5468

## CERTIFICATE OF DEATH

05457

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>				c. LENGTH OF STAY IN 1b <b>11yr. 5mo. 26da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Carl</b> Last <b>Heinecke</b>				4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-24-83</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Frederick Heinecke</b>				14. MOTHER'S MAIDEN NAME <b>Anna Feldsman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>214-03-5440-1</b>			
17. INFORMANT <b>Records Springfield State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Gangrene of right foot</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b). <b>Arteriosclerotic aneurysms of common iliac artery. ?</b> DUE TO (c). <b>Generalized arteriosclerosis, severe.</b> Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Chronic brain syndrome associated with alcohol intoxication with psychotic reaction.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>--</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 31</b> 19 <b>55</b> , to <b>May 17</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 17</b> 19 <b>59</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5-17-59</b>							
ACTUAL SIGNATURE <b>Walter Knopp</b> M.D.				PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		22d. LOCATION (City, town, or county) (State) <b>Baeto</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur &amp; Thoma</b>				24. REC'D BY REGISTRAR <b>MAY 20 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thoma</b>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G242 5-12-59 et

## CERTIFICATE OF DEATH

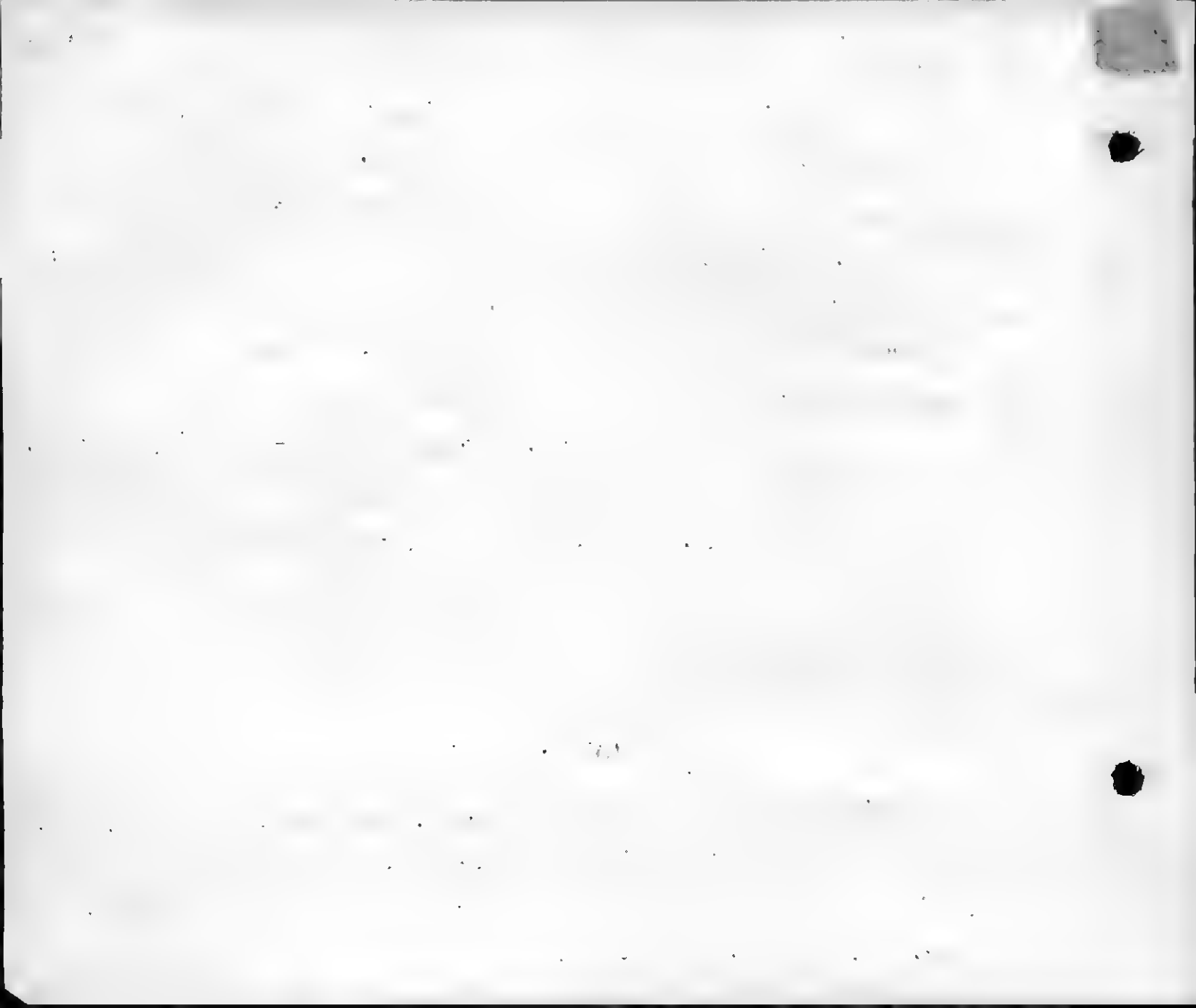
Reg. Dist. No.

05458

5469

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Private home"</u>		d. STREET ADDRESS <u>1835 Edgewood Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mrs.</u> Middle <u>Margaret</u> Last <u>Hieber</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2nd</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Auffarth</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Loos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT <u>Mr. Charles Hieber - 1833 Edgewood Rd.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOV - 11</u> , 19 <u>58</u> , to <u>MAY - 2</u> , 19 <u>59</u> that I last saw the deceased alive on <u>MAY - 2</u> , 19 <u>59</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>201 E. 33rd Street Baltimore, Maryland</u> DATE SIGNED <u>5/4/59</u>			
ACTUAL SIGNATURE <u>Stuart D. Sunday</u>		PHYSICIAN'S NAME (Type) <u>STUART D. SUNDAY</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '59</u>	
ADDRESS <u>5305 Harford Road</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

5470

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

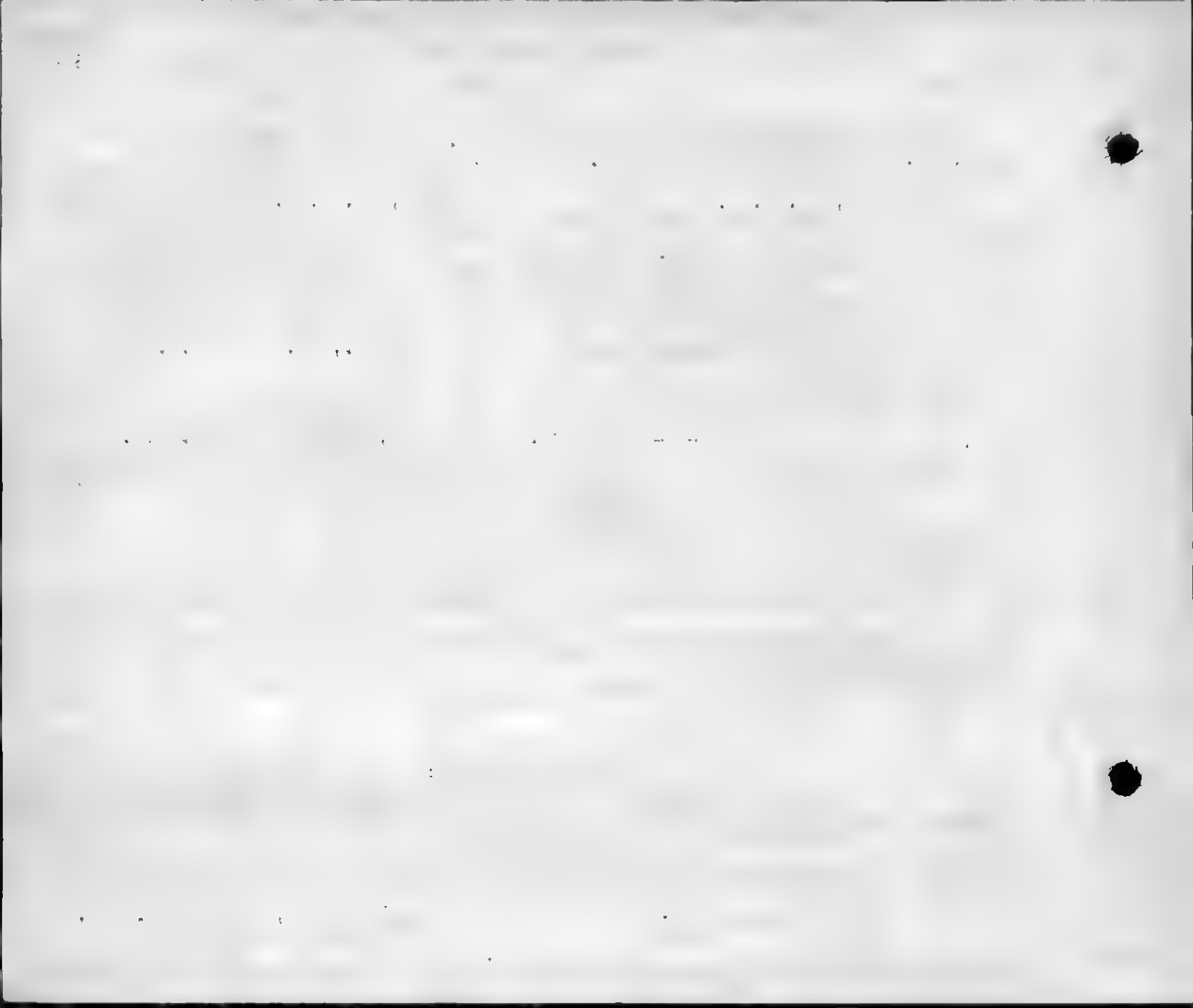
CERTIFICATE OF DEATH

05459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Mills Rural, Nr. Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster - (Union Mills)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R. D. 2</b>		d. STREET ADDRESS <b>Westminster, Md. R. D. 2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Leslie</b> Middle <b>A.</b> Last <b>Irvin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23/1883</b>
9. AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Home</b>	11. BIRTHPLACE (State or foreign country) <b>Washington Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samuel Irvin</b>		14. MOTHER'S MAIDEN NAME <b>Alice Marie Switcher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-32-1748</b>	
17. INFORMANT <b>Mrs. Mabel Irvin, Westminster, Md. R.D.2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis &amp; myocardial degeneration</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aneurysm of Aorta</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-15</b> , 19 <b>58</b> , to <b>5-26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-26</b> , 19 <b>59</b> , and that death occurred at <b>10:15 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. L. Potter</b>		ADDRESS (Street, city or town, state) <b>12 W. King St. Littlestown, Pa</b>	
PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>		DATE SIGNED <b>5-27-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

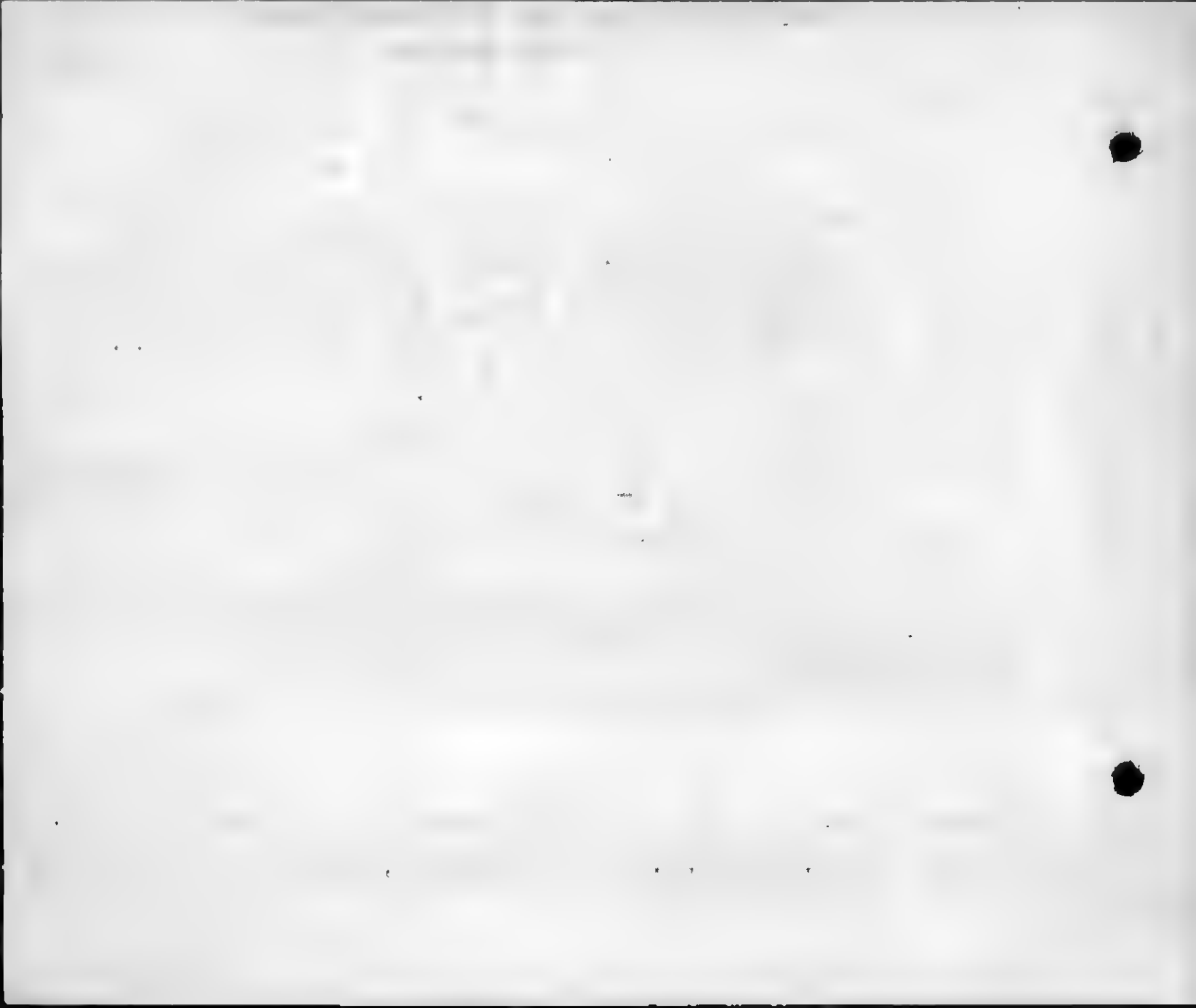
5471

## CERTIFICATE OF DEATH

Reg. Dist. No. 05460

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>43 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>R.</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 23, 1877</b>
9 AGE (In years last birthday) yrs <b>80</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Mary G. Rawlings</b>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>--</b>		17 INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> <b>420.0</b> DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> (c) <b>Schizophrenic reaction, paranoid type</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>58</b> , to <b>May 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 9</b> , 19 <b>59</b> , and that death occurred at <b>10:25 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rita S. Glahn</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5-9-59</b>	
PHYSICIAN'S NAME (Type) <b>Rita S. Glahn, M. D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>5-12-59</b>	<b>All Saints</b>	<b>Sunderland Md</b>
23 FURNERAL DIRECTOR'S SIGNATURE <b>Hutchins Funeral Home, Wiggins Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 13 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





5472

## CERTIFICATE OF DEATH

05461

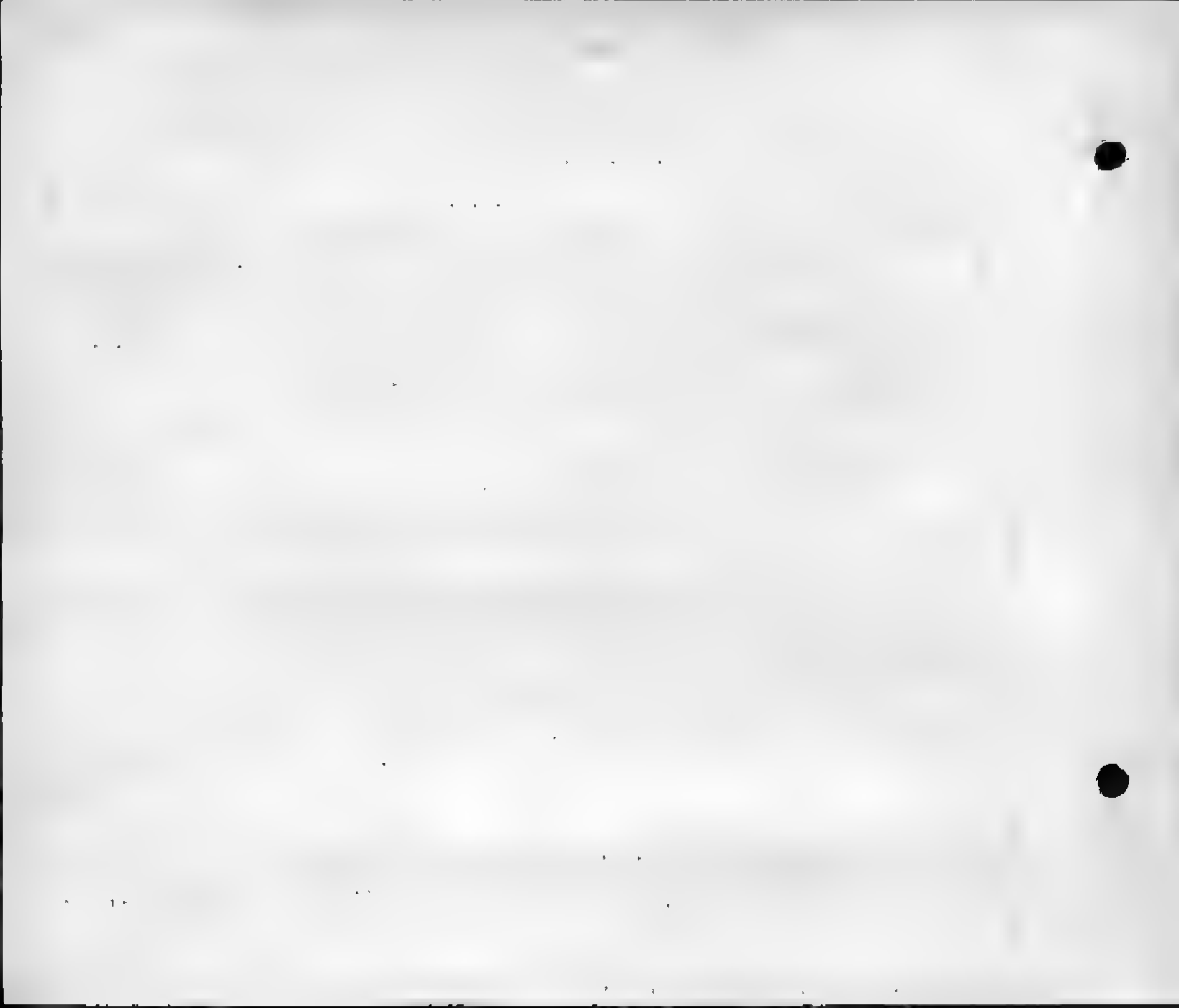
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>				c. LENGTH OF STAY IN 1b <b>4 y. 3m. 1d.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				/d. STREET ADDRESS <b>R.F.D. #1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Virginia</b> Last <b>Koontz</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 6, 1876</b>	
9. AGE (In years last birthday) yrs <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry Koontz</b>				14. MOTHER'S MAIDEN NAME <b>Mary -- Prock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Springfield State Hospital Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pleural pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH Hours  Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m. Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>November 18, 1958</b> to <b>May 8, 1959</b> , that I last saw the deceased alive on <b>May 8, 1959</b> , and that death occurred at <b>3:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oak Street</b> DATE SIGNED <b>5/8/59</b>							
ACTUAL SIGNATURE <b>Konstantin Weber</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Konstantine Weber, M. D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

Richard A. Little, Littlestown, Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5473

Item 2 4-1-59 6-9-59 et

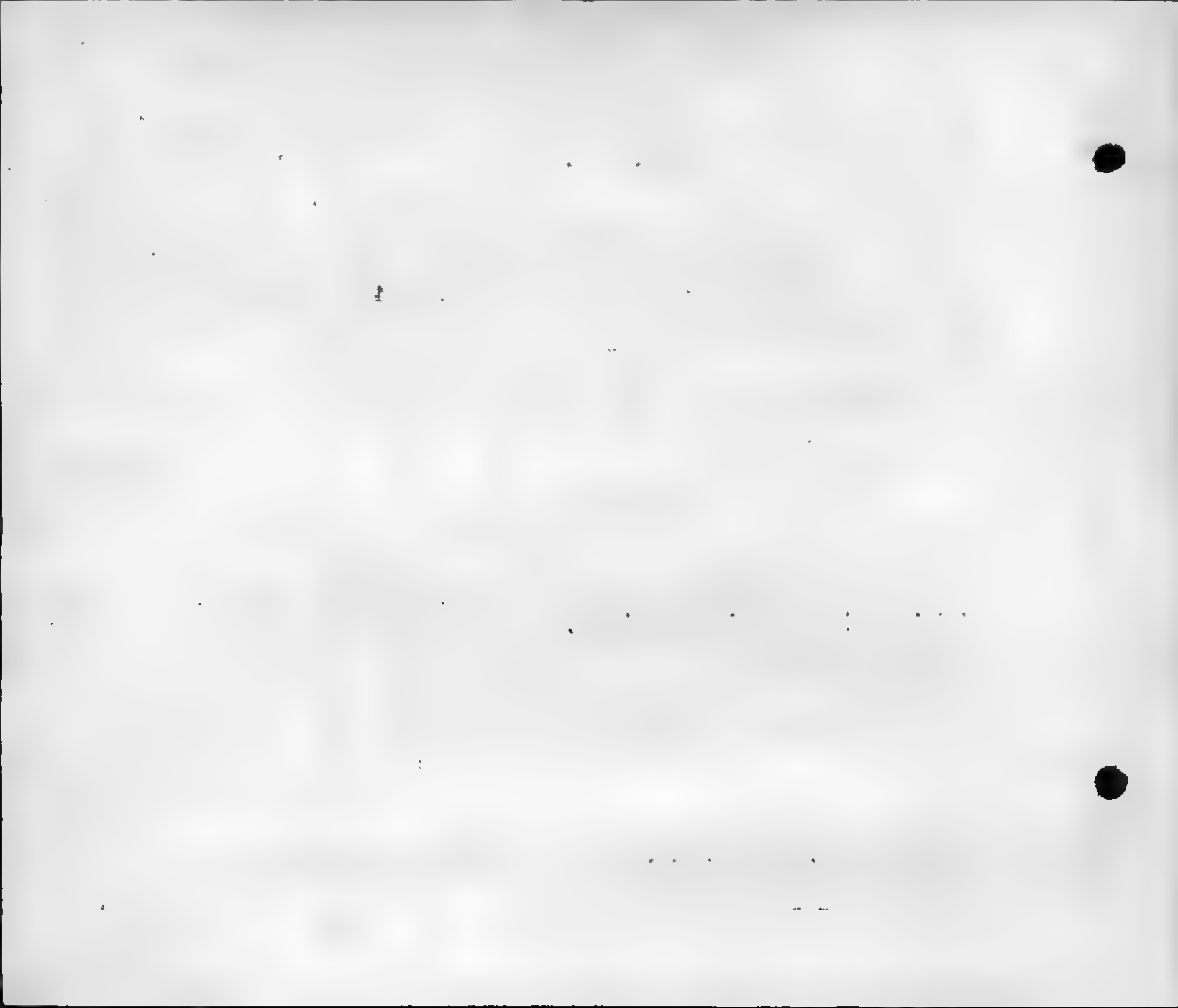
## CERTIFICATE OF DEATH

05462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2yrs. 1 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2746 W. Lafayette Baltimore 2.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Winifred</b> Last <b>Herbert Lawrence</b>				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 22, 1884</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>							
13. FATHER'S NAME <b>John Herbert</b>				14. MOTHER'S MAIDEN NAME <b>Winifred Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> DUE TO (c) <b>-</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of metab. growth or nutrition, with senile brain disease, with psychotic reaction.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 30, 1957</b> , to <b>May 28, 1959</b> , that I last saw the deceased alive on <b>May 28, 1959</b> , and that death occurred at <b>11:00A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5/28/59</b>							
ACTUAL SIGNATURE <b>Ives H. Boennec</b> M.D.				PHYSICIAN'S NAME (Type) <b>Ives H. Boennec, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-1-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Howard Strong</b> ADDRESS <b>3607 W. North Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5474 CERTIFICATE OF DEATH

05463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN b. <b>1yr. 4mos. 21days</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>105 W. 2nd St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Sarah Sabilla Snyder</b> Middle <b>Littlefield</b> Last <b>Littlefield</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 29, 1867</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min <b>12</b>	IF UNDER 24 HRS Hours <b>12</b> Min <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas E. Snyder</b>	
14. MOTHER'S MAIDEN NAME <b>Cornelia Vanderveer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>York</b>		Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>December 14, 19 57</b> , to <b>May 5, 19 59</b> , that I last saw the deceased alive on <b>May 5, 19 59</b> , and that death occurred at <b>9:20P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		DATE SIGNED <b>5/6/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-8-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Long Branch N. J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Haggard</b>		ADDRESS <b>Springfield, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haggard</b>	

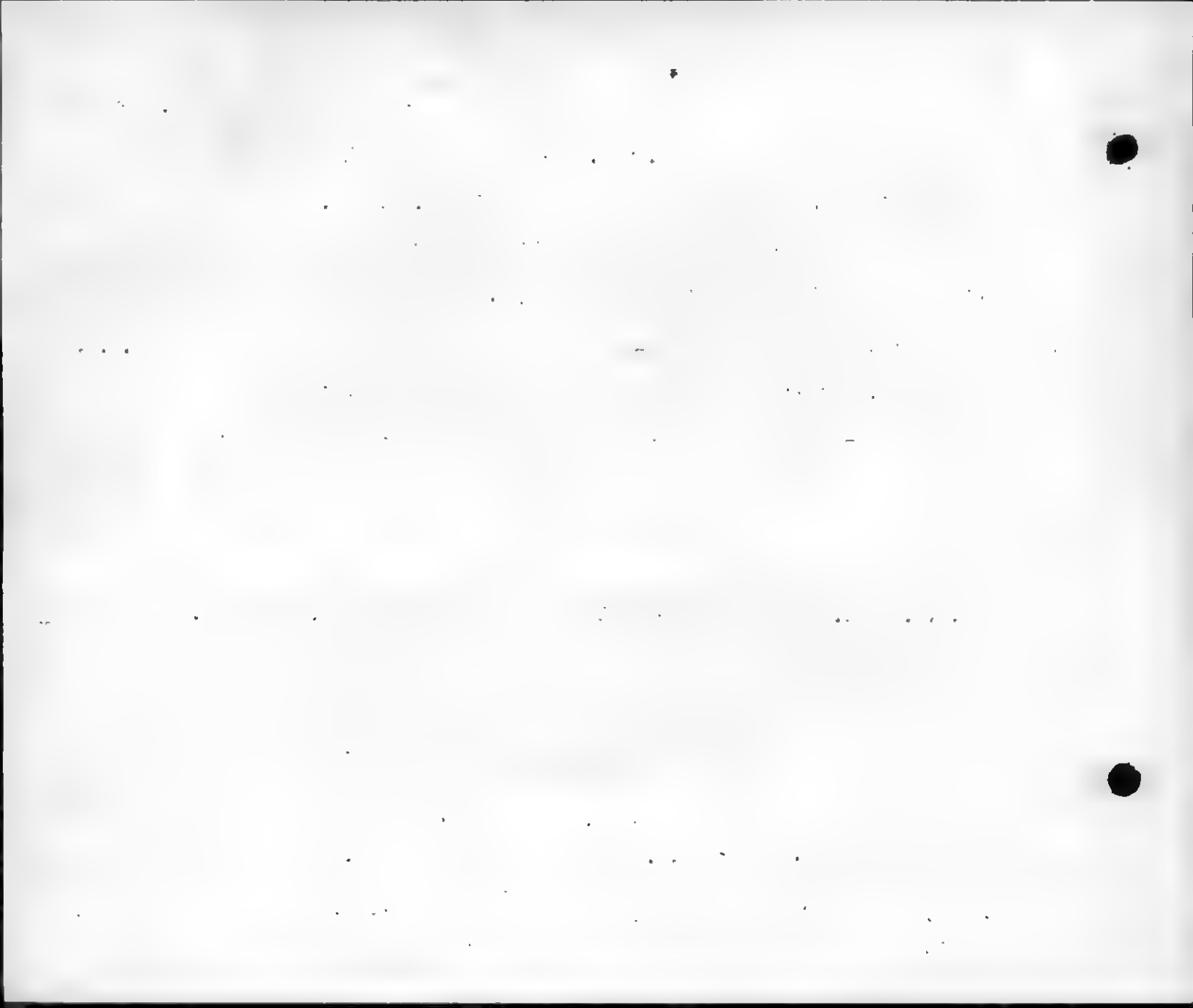
1

Page 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the "a" certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



## 5475 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>11 mos. 19 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Balto. 31.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Malinski</b> Last <b>Malinski</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1881</b>
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>213-12-0022</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>443X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 3, 1958</b> to <b>May 22, 1959</b> that I last saw the deceased alive on <b>May 21, 1959</b> , and that death occurred at <b>8:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5/22/59</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/24/59</b>	22c. NAME OF CEMETERY OR BURIAL PLACE <b>ST. STANISLAUS</b>	22d. LOCATION (City, town, or county) (State) <b>6575 BOSTON ST BALTO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George G Weber 705 S Ann st</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frame</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5476 CERTIFICATE OF DEATH

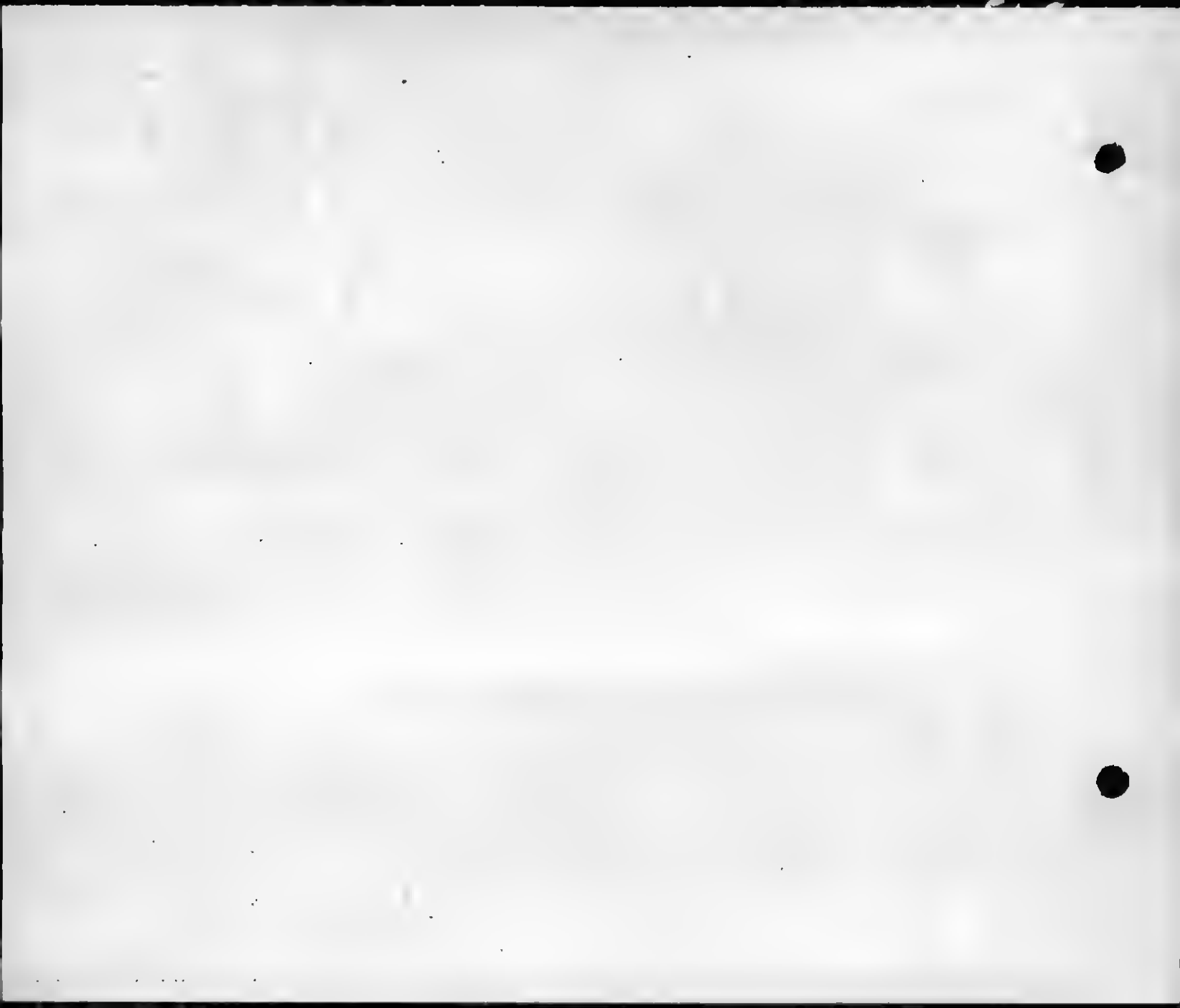
05465

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Burrall</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Burrall</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ETTA - L - MARKEL</u>		4. DATE OF DEATH <u>May 4 - 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16 - 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David M. Bilhaut</u>		14. MOTHER'S MAIDEN NAME <u>Eda. Cultrides</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>704-5-11111</u>	
17. INFORMANT <u>John E. Markel, Manchester Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Myocardial Infarction</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 4, 1959</u> to <u>May 4, 1959</u> , that I last saw the deceased alive on <u>May 4, 1959</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.H. Frouard</u> M.D.		ADDRESS (Street, city or town, state) <u>Manchester Md</u> DATE SIGNED <u>5/5/59</u>	
PHYSICIAN'S NAME (Type) <u>W.H. Frouard M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester Md</u>		22d. LOCATION (City, town, or county) (State) <u>Burrall Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. A. Tipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>May 7 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2:57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05466

Item 20 Film 242 5-14-59

Item 9 Film 242 5-14-59 et

1. PLACE OF DEATH a COUNTY <b>Carroll</b> <b>5477</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>		
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c LENGTH OF STAY IN it <b>8 mos. 11 days</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d STREET ADDRESS <b>9810 Georgia Ave.</b>		
3. NAME OF DECEASED (Type or print) <b>Frank Raleigh Mason</b>			4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1881</b>		9. AGE (In years, months, days, hours, minutes) <b>77 1/2 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown Va.</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Mary Hughes</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>YES -</b>		17. INFORMANT <b>Springfield State Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hemorrhage (traumatic)</b> <b>4 d. d. l.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>Years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell, probably in some sort of seizure</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>4/23/1959</b> o. m. <b>4</b> p. m. <b>23</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Sykesville</b>	(County) <b>Carroll</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James T. Marsh</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 7, 1959.</b>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-11-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b>		ADDRESS <b>1400 Chapman St.</b>		24a. REC'D BY REGISTRAR <b>MAY 11 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

MEDICAL CERTIFICATION

2

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

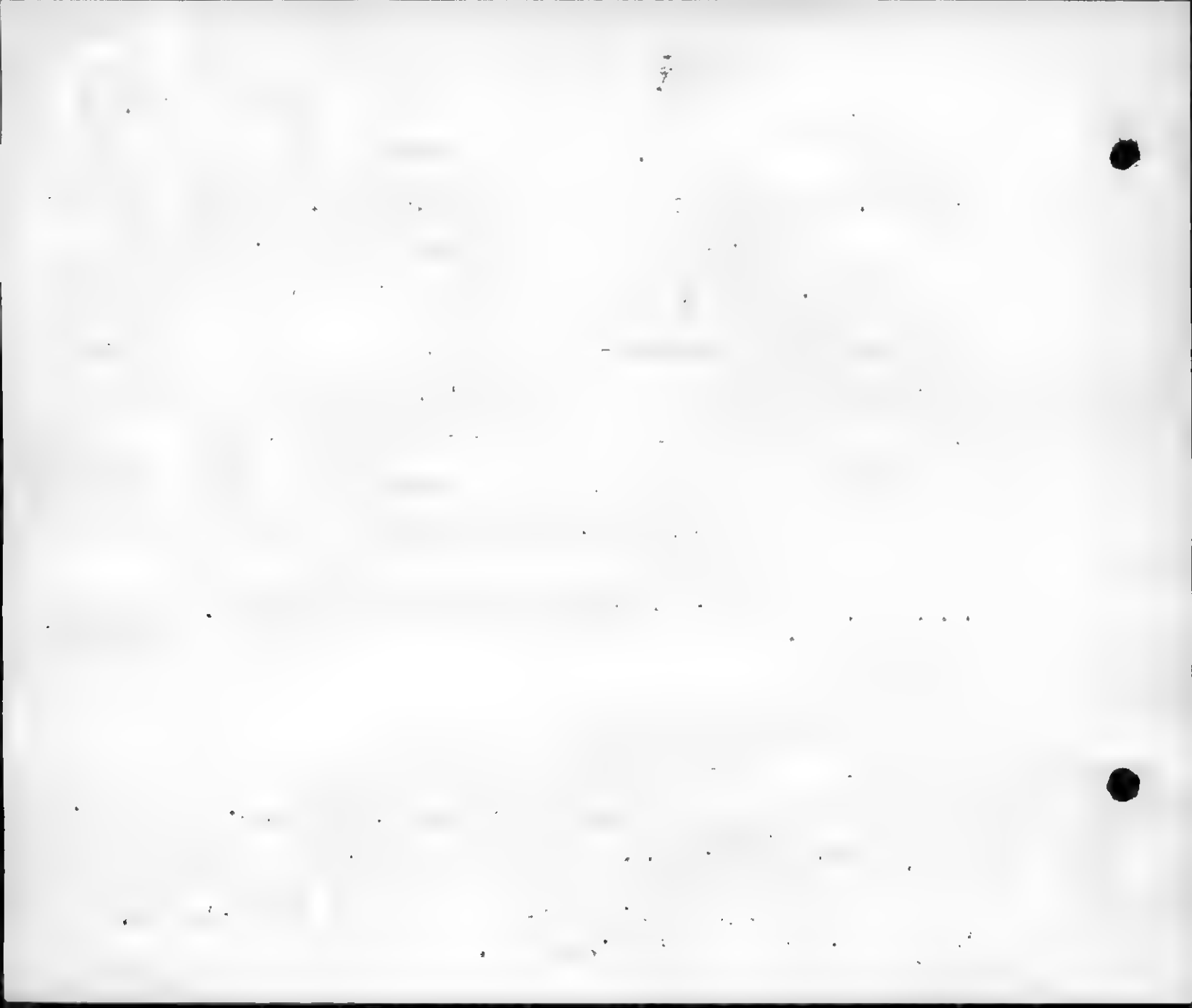
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05467

## 5478 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>9mos. 14days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Enrico</b> Middle Last <b>Maulone</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1885</b>
9. AGE (In years last birthday) yrs <b>74</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired-</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>1st papers</b> ✓	
13. FATHER'S NAME <b>Antonio Maulone</b>		14. MOTHER'S MAIDEN NAME <b>Christine Cavatossi</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>213-07-7425</b>	
INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Bronchopneumonia.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 21, 1958</b> to <b>May 5, 1959</b> , that I last saw the deceased alive on <b>May 5, 1959</b> , and that death occurred at <b>9:15P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		DATE SIGNED <b>5/6/59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) (State) <b>7401 Geman Hill Rd.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fraule Della Noce</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '59</b>	
ADDRESS <b>322 S. High St.</b>		24b. REGISTRAR'S SIGNATURE <b>Carling S. Kraus</b>	



## 5479 CERTIFICATE OF DEATH

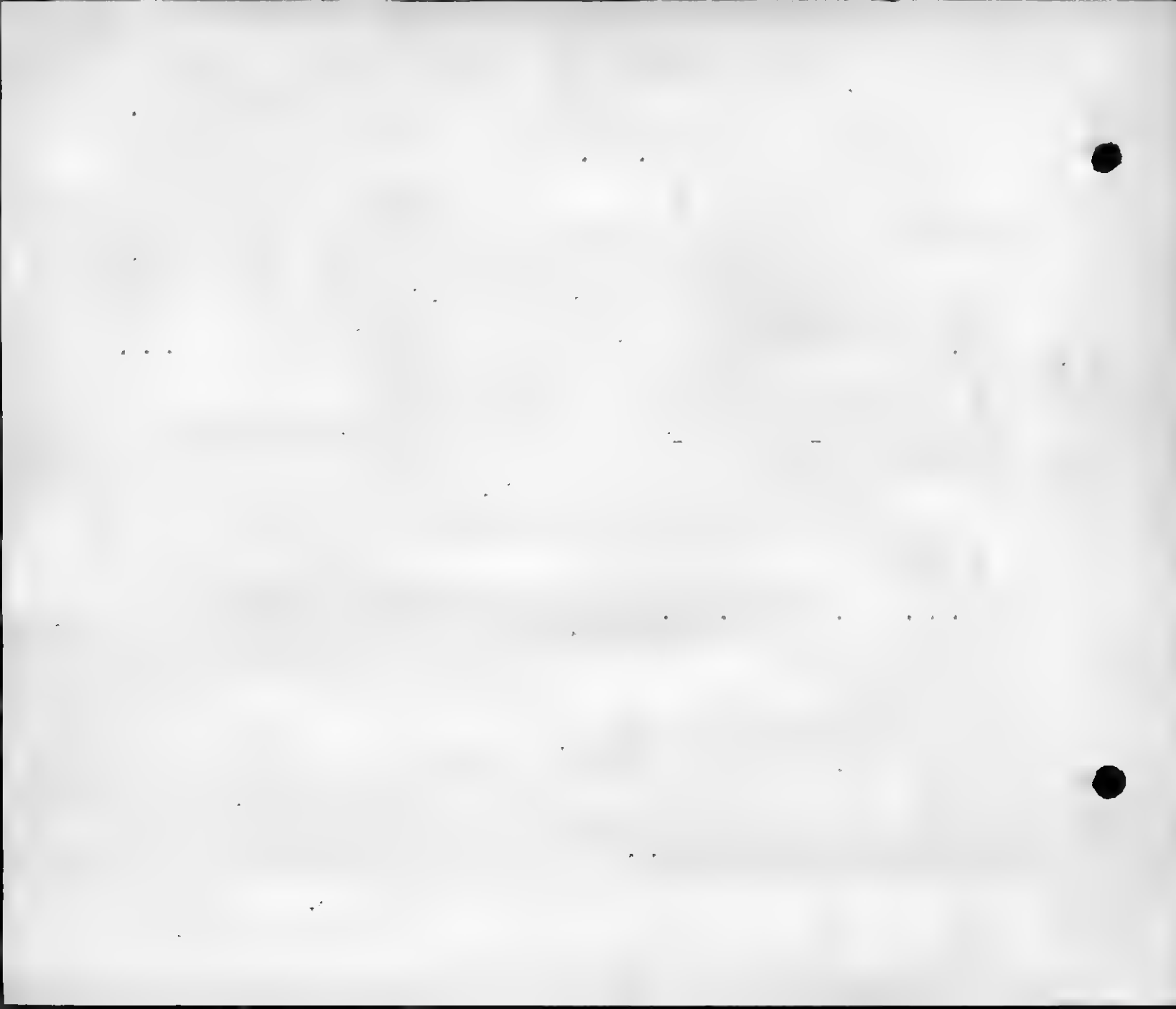
Reg. Dist. No.

05468

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN IB <b>4yrs. 8mos. 12days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Coy</b> Last <b>McArdle</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maritime</b>	11. BIRTHPLACE (State or foreign country) <b>Unknown</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <b>216-12-2249</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic vulvulitis, active</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist. other than cerebral arteriosclerosis with psychotic reaction.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>May 28, 1959</b> , that I last saw the deceased alive on <b>May 27, 1959</b> , and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>5/28/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-30-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frederick</b>	22d. LOCATION (City, town, or county) (State) <b>Springfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Thomas</b>		24. REC'D BY REGISTRAR DATE <b>JUN 2 '59</b>	
25. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05469

5480

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jamestown</u>		c. LENGTH OF STAY IN 1b <u>18 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jamestown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R2</u>				d. STREET ADDRESS <u>1 R2</u>			
3. NAME OF DECEASED (Type or print) <u>VIOLET MAE MILLER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1900</u>		9. AGE In years (last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R Baker</u>				14. MOTHER'S MAIDEN NAME <u>Anna Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-40-1589</u>		17. INFORMANT <u>Wm J Miller</u> Address <u>Jamestown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James J. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keysville, Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, or in any event within 72 hours after death.



5481

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05470

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>15yrs. 14days. 11mos.</b> <b>Baltimore 18</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1637 Argonne Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Ernest Milleson</b>		4. DATE OF DEATH <b>May 22, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1909</b>
9. AGE (in years last birthday) <b>50</b> yrs		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Milleson</b>		14. MOTHER'S MAIDEN NAME <b>Nora Cadwalder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis - pericarditis</b> <b>4 d. d. d.</b> DUE TO (b) <b>Purulent bronchitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Epilepsy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Psychosis with conv. disorder, epileptic deterioration.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY <b>1:30 PM. 5/8/ 19 59</b>		20d. INJURY OCCURRED <b>While of work</b> <input type="checkbox"/> <b>Not while of work</b> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Sykesville</b> (County) <b>Carroll</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>5/25/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>		22d. LOCATION (City, town, or county) <b>Balto</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leland J. Luck</b>		24a. REC'D BY REGISTRAR <b>MAY 26 '59</b>	
ADDRESS <b>5305 Harbor Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Truesdell</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21 Film ... by Phone to Dr. Marsh - 6/11/59 ams

## 5482 CERTIFICATE OF DEATH

05471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frizzelburg</b>		c. LENGTH OF STAY IN 1b <b>65 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>R.</b> Last <b>Myers</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 16, 1860</b>
9. AGE (In years last birthday) <b>99</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emanuel Koontz</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Monchey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mr. Norman Myers</b>		Address <b>Route #7, Westminster, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal Disease</b> <b>442 x</b> DUE TO <b>Myocardial Degeneration &amp; Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <b>Senility &amp; Arteriosclerosis</b> (b) <b>Senility &amp; Arteriosclerosis</b> (c) <b>Senility &amp; Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Several yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (or 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 15, 1959</b> , to <b>May 8, 1959</b> , that I last saw the deceased alive on <b>May 8, 1959</b> , and that death occurred at <b>2:45 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>		ADDRESS (Street, city or town, state) <b>Westminster, Md.</b>	
DATE SIGNED <b>5/9/59</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Krider's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Westminster, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> <b>G. O. Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5483 CERTIFICATE OF DEATH

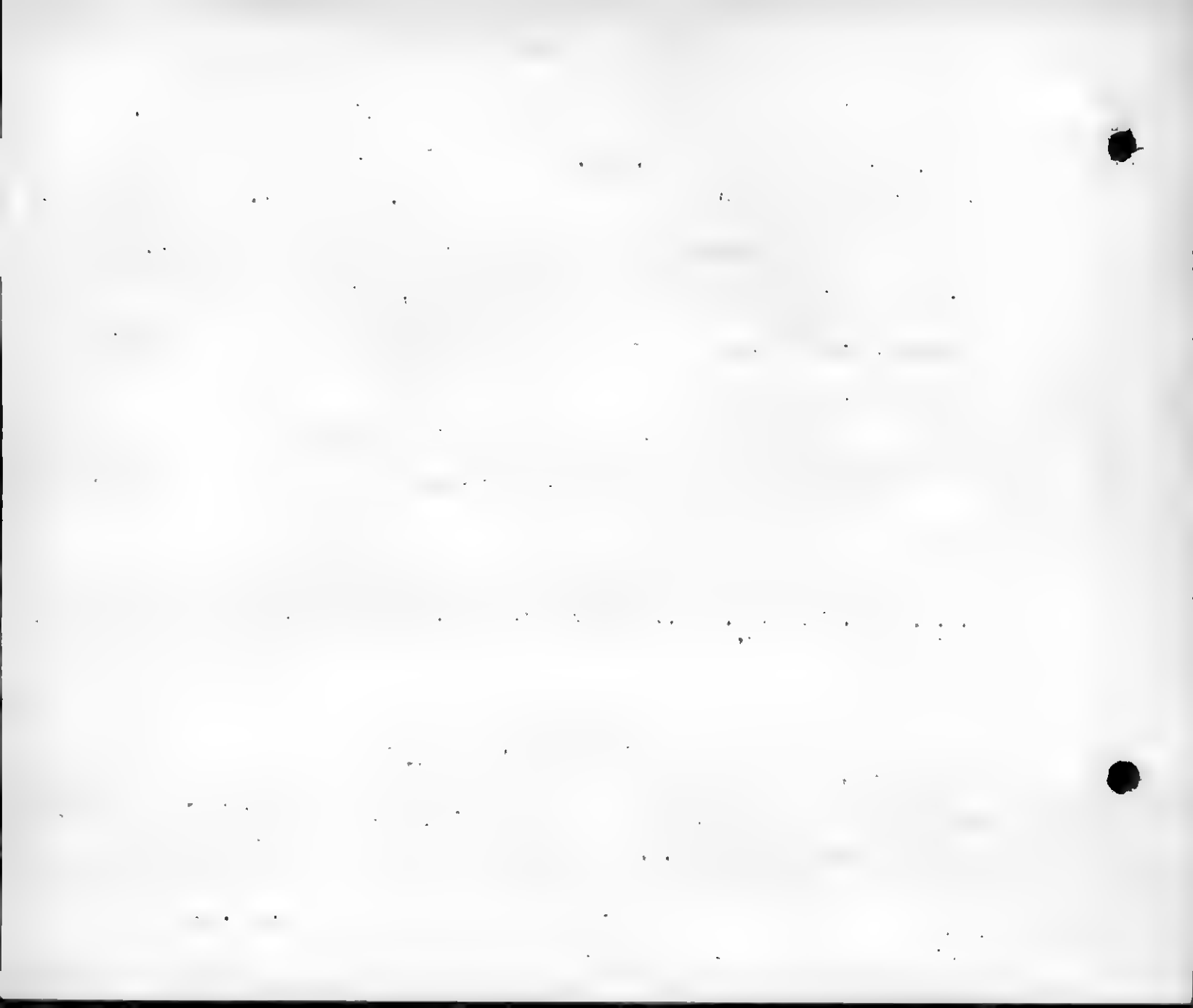
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>4yrs. 7mos. 24days</b>		d. STREET ADDRESS <b>104 E. Lanvale St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hannah</b> Middle <b>Newbon</b> Last <b>Newbon</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>October 29, 1877</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. <b>81</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Retired Maid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>James Newbon</b>		14. MOTHER'S MAIDEN NAME <b>Sara Cotton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>	
INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic lymphoid leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>September 8, 1954</b> , to <b>May 2, 1959</b> , that I last saw the deceased alive on <b>May 1, 1959</b> , and that death occurred at <b>4:37A</b> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
DATE SIGNED <b>5/2/59</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>May 6, 1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>			
22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H. N. Means &amp; Son 805 N. Calvert St.</b>			
24a. REC'D BY REGISTRAR <b>MAY 4 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kenna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**5484 CERTIFICATE OF DEATH**

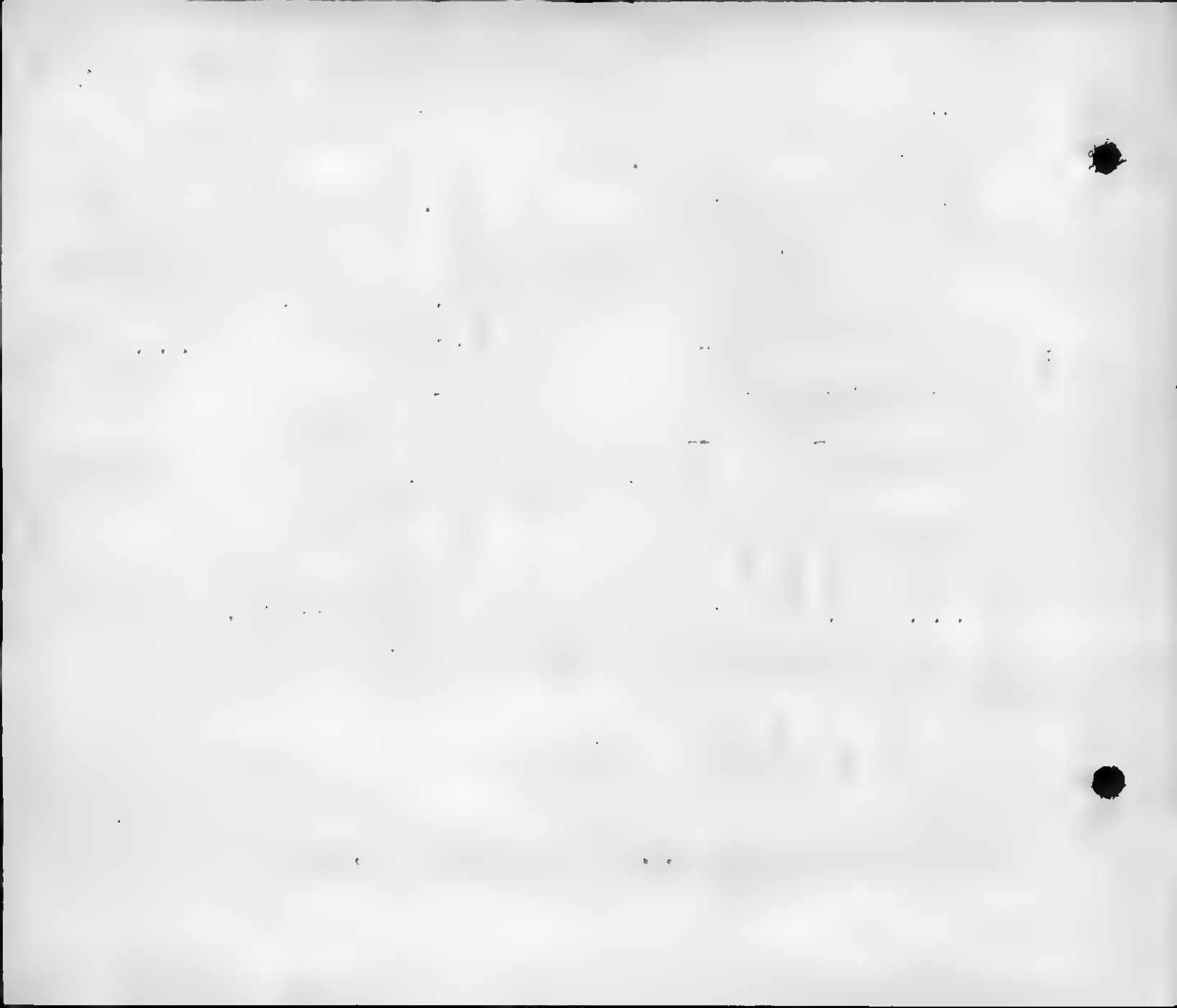
Reg. Dist. No.

**05473**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>3 mo. 7 days</b>				d. STREET ADDRESS <b>513 N. Castle Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Hierstetter</b> Last <b>Nohe</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>July 28, 1867</b>	9. AGE (In years last birthday) <b>91</b> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawrence Hierstetter</b>				14. MOTHER'S MAIDEN NAME <b>- Rose Yaeger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4 . 0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease, with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>February 15, 1959</b> , to <b>May 22, 1959</b> , that I last saw the deceased alive on <b>May 22, 1959</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5/22/59</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D. <b>Springfield State Hospital</b>					
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 26, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore-6, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

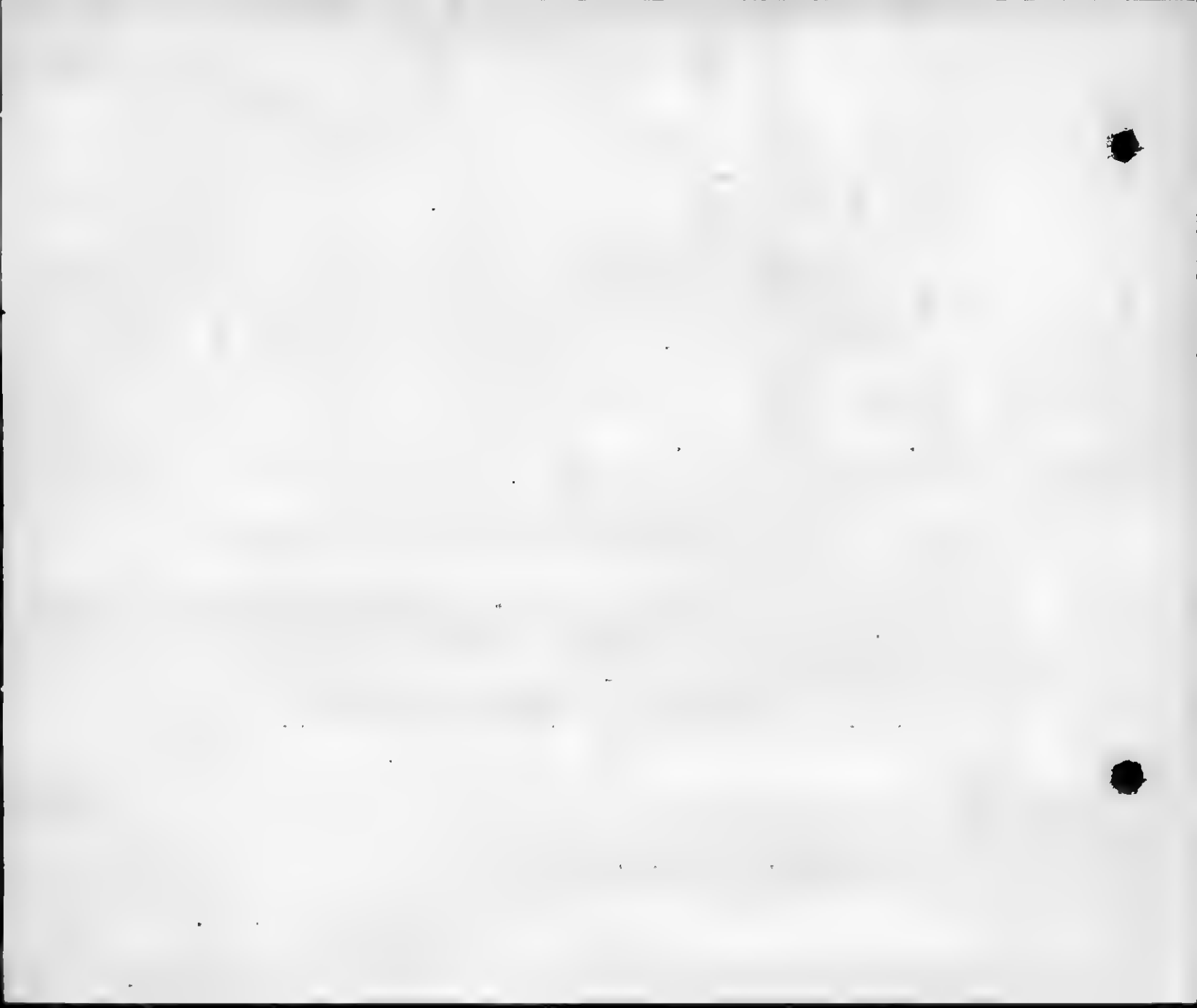


Reg. Dist. No. 05474

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPITAL</b>				d. STREET ADDRESS <b>29 East Elm Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FREDERICK AUGUST OBERENDER</b>		First Middle Last		4. DATE OF DEATH <b>5 21 19 59</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/22/1866</b>	
9. AGE (In years last birthday) <b>92</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unk.</b>		16. SOCIAL SECURITY NO <b>unk.</b>		17. INFORMANT <b>Record, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio-vascular heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>----</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. <b>----- 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>5/6</b> , 19 <b>59</b> , to <b>5/21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/21</b> , 19 <b>59</b> , and that death occurred at <b>10 A DST</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gertrude M. Gross, M.D.</b>		M.D.		ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b>		DATE SIGNED <b>5/21/59</b>	
PHYSICIAN'S NAME (Type) <b>Gertrude M. Gross, M. D.</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Howard</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

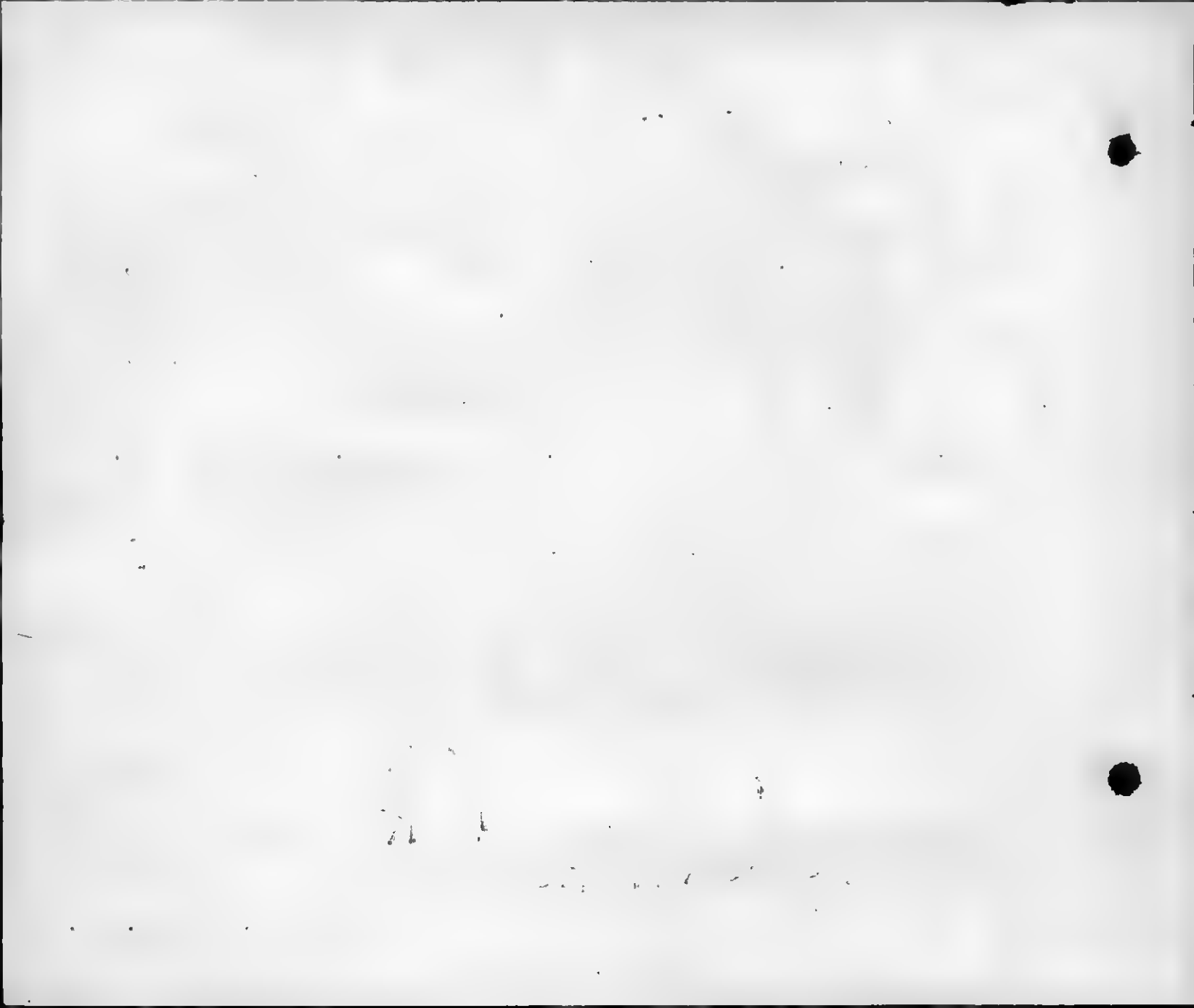
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## CERTIFICATE OF DEATH

Reg. Dist. No.

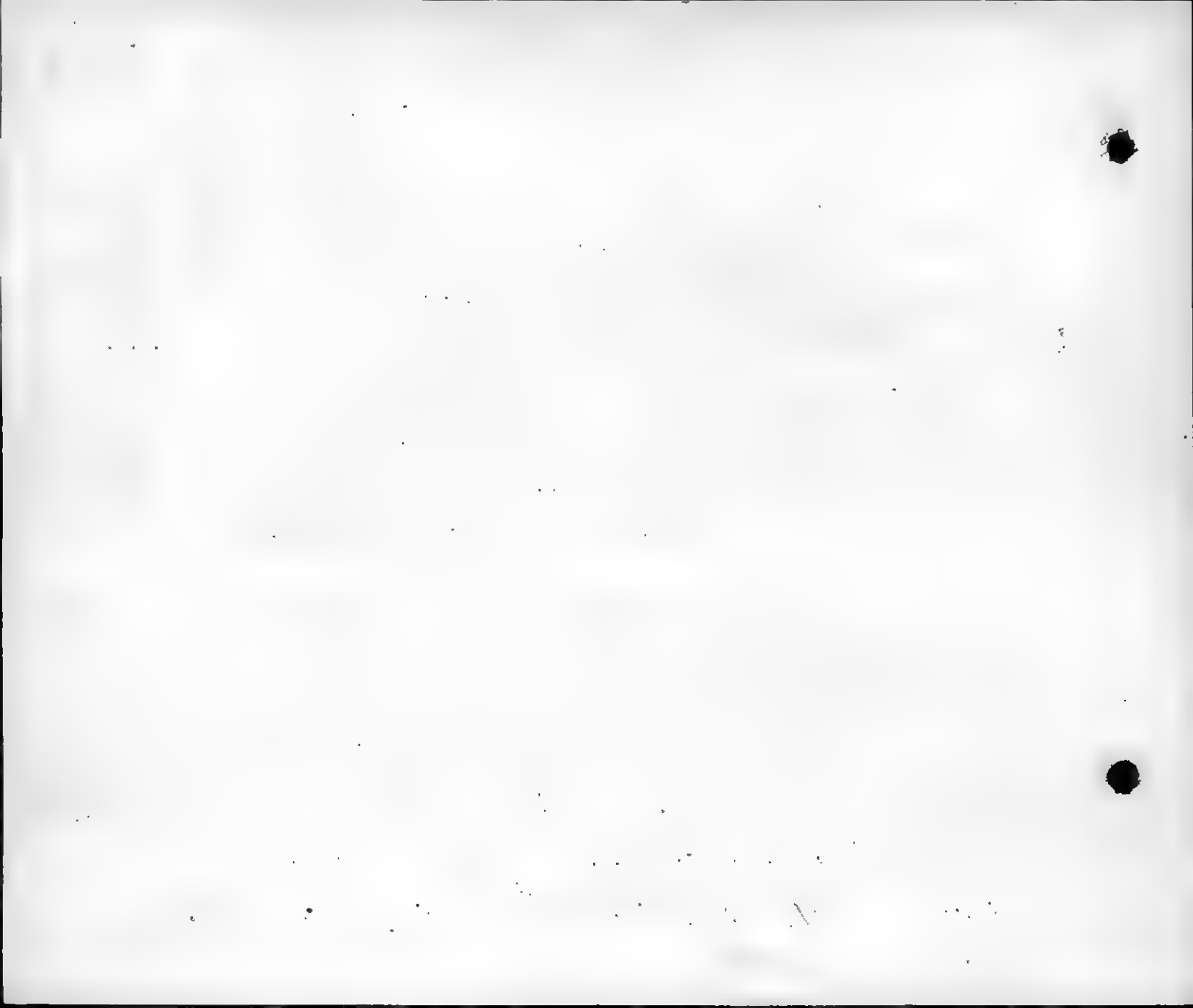
05475

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster-Rural</b> c. LENGTH OF STAY IN 1b <b>Westminster-Rural</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Meadow View Convalescent Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westminster,</b> d. STREET ADDRESS <b>No street address</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>W. Halbert Poole</b>		4. DATE OF DEATH Month Day Year <b>May 29, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1875</b> 9. AGE (In years last birthday) yrs <b>83 5/8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stable operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stable operator</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Poole</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Mealy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>W. Halbert Poole Jr., Gaithersburg, Md.</b>	
17. INFORMANT <b>W. Halbert Poole Jr., Gaithersburg, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>433.1 Cerebral Thrombosis</b> DUE TO (b) <b>Auricular fibrillation</b> DUE TO (c) <b>12 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>moderate arteriosclerosis</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>moderate arteriosclerosis</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>19</b>	
20e. (City or town) <b>19</b>		20f. (County) <b>19</b>	
20g. (State) <b>19</b>		21. I certify that I attended the deceased from <b>June 2, 1959</b> to <b>May 29, 1959</b> , that I last saw the deceased alive on <b>May 29, 1959</b> , and that death occurred on <b>May 29, 1959</b> , from the causes and on the date stated above.	
21. I certify that I attended the deceased from <b>June 2, 1959</b> to <b>May 29, 1959</b> , that I last saw the deceased alive on <b>May 29, 1959</b> , and that death occurred on <b>May 29, 1959</b> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <b>45 Kempner Ave Westminister Md</b>	
22. ACTUAL SIGNATURE <b>E Reese Wilkens</b> PHYSICIAN'S NAME (Type) <b>E Reese Wilkens</b>		22. DATE THEREOF <b>6/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Central Cemetery</b>		22d. LOCATION (City, town, or county) <b>Libertytown, Fred, Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b> ADDRESS <b>Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		24c. DATE <b>JUN 2 '59</b>	



VS A15 (4)  
15M 9/11

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>2849 Spellman Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Elizabeth</b> Last <b>Powell</b>				4. DATE OF DEATH Month <b>5</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-18-1921</b>	
				9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Woolford</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Dennis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		INFORMANT Address <b>Clara E. Powell - Patient</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 22, 1959</b> to <b>May 17, 1959</b> that I last saw the deceased alive on <b>May 17, 1959</b> and that death occurred at <b>12:30 p. m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>5-17-59</b> ACTUAL SIGNATURE <b>Edgars M. Maculans M.D.</b> PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M.D.</b> <b>Henryton State Hospital</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Miss R. Williams</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

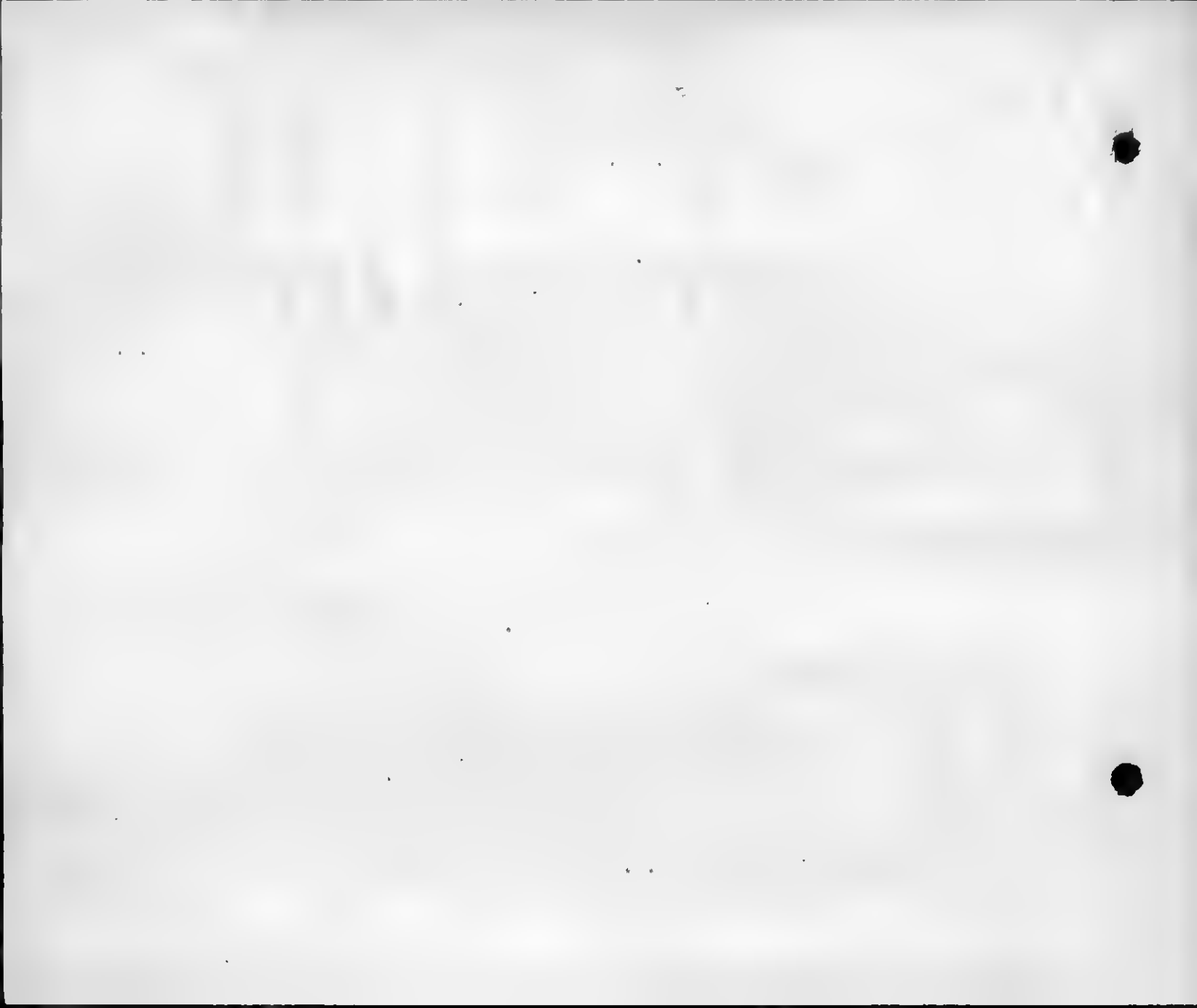
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5488 CERTIFICATE OF DEATH

05477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>		c. LENGTH OF STAY IN 1b <u>5yr. 7mo. 10da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> <u>2V31-4</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGFIELD STATE HOSPITAL</u>			d. STREET ADDRESS <u>1531 Bush Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>L. (Wallace)</u> Last <u>REED</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland - Baltimore</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Wallace</u>			14. MOTHER'S MAIDEN NAME <u>Annie Ochse Heter</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain disease with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
19a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>10-8</u> , 19 <u>53</u> , to <u>5-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-18</u> , 19 <u>59</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>5-18-59</u>					
ACTUAL SIGNATURE <u>Myron Nizankowsky</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Myron Nizankowsky, M.D.</u>		<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Am. Cook, Inc., 1217 St. Paul Street</u>			24a. REC'D BY REGISTRAR <u>MAY 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>



## 5488 CERTIFICATE OF DEATH

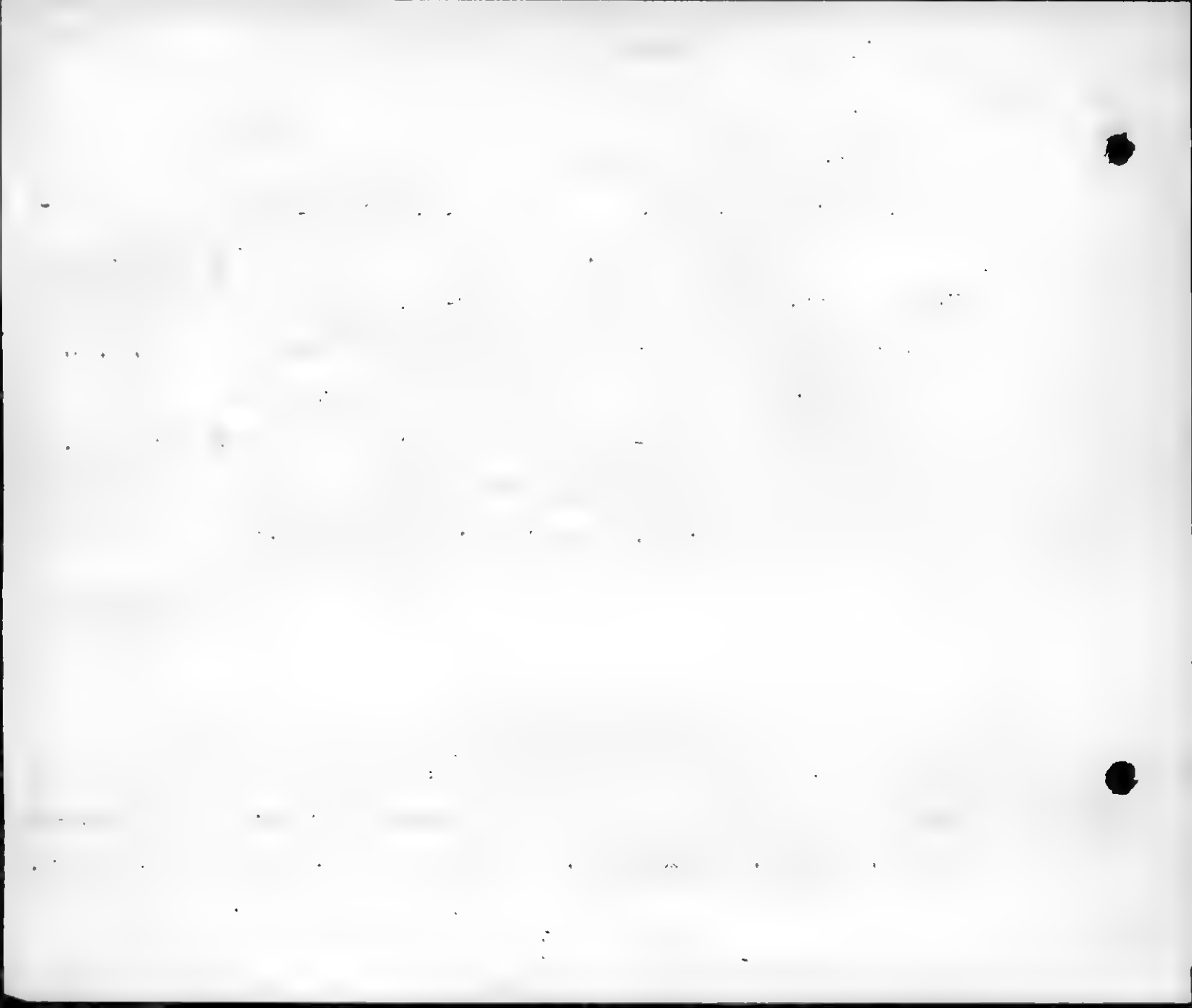
Reg. Dist. No.

05478

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived IF institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. STREET ADDRESS <b>1604 Barclay Street</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>H.</b> Last <b>Reed</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-11-17</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Reed</b>		14. MOTHER'S MAIDEN NAME <b>Betty Vaughn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-01-1613</b>	
INFORMANT <b>Mildred Reed</b>		Address <b>1604 Barclay St.</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b>			
DUE TO (b) <b>Far adv. pulmonary TB and delirium tremens</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 30, 1959</b> to <b>May 11, 1959</b> that I last saw the deceased alive on <b>May 11, 1959</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edgars M. Maculans</b> M.D.		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>5-11-59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt.</b>		<b>Henryton State Hospital, Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	22b. DATE THEREOF <b>5-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>	22d. LOCATION (City, town, or county) (State) <b>A.A. Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel W. Sullivan Jr</b> ADDRESS <b>Beth Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

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5490

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on. Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>GEORGE - A - RUBY</u>		4. DATE OF DEATH <u>May 14 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>12-31-1882</u>	9. AGE (In years, months, days) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
13. FATHER'S NAME <u>John Ruby</u>		14. MOTHER'S MAIDEN NAME <u>Anna Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17</u>	
17. INFORMANT <u>Elmo Ruby - Hampstead Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> DUE TO (c) <u>Due to</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/14/59</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or MOVING (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Shipton</u>		24a. REC'D BY REGISTRAR <u>May 19 1959</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5491 CERTIFICATE OF DEATH

05480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b <b>Taneytown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>W. Baltimore Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>Eckard</b> Last <b>Shorb</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 30, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>John W. Eckard</b>		14. MOTHER'S MAIDEN NAME <b>Susan Alice Althouse</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>John Edward Shorb, Taneytown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Degeneration (non specific)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>few min</b> <b>10 yrs</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5</b> , 19 <b>59</b> , to <b>May 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 5</b> , 19 <b>59</b> , and that death occurred at <b>11:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Frederick St, Taneytown, Md</b> DATE SIGNED <b>5/8/59</b>			
ACTUAL SIGNATURE <b>E. Ambler Thompson</b>			
PHYSICIAN'S NAME (Type) <b>E A THOMPSON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 9, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Maryland</b>	24a. REC'D BY REGISTRAR <b>MAY 11 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

1  
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15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5492 CERTIFICATE OF DEATH

05481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Millers</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Millers</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rupp Rd.</u>		d. STREET ADDRESS <u>Rupp Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Michael Lee Simpson</u>		4. DATE OF DEATH <u>May 28 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27 1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>York Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. Merle Simpson</u>		14. MOTHER'S MAIDEN NAME <u>Jean Smeltzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Merle Simpson</u>		Address <u>Millers, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>442</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hydrocephalus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>8 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 2</u> , 19 <u>51</u> , to <u>May 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 28</u> , 19 <u>59</u> , and that death occurred at <u>12 p. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foard</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Manchester Md 5/28/59</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>		<u>Manchester Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 31 1959</u>	<u>Free Meth. Cemetery</u>	<u>Alesia, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Local Mortuary New Freedom</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
		DATE <u>JUN 2 '59</u>	



05482

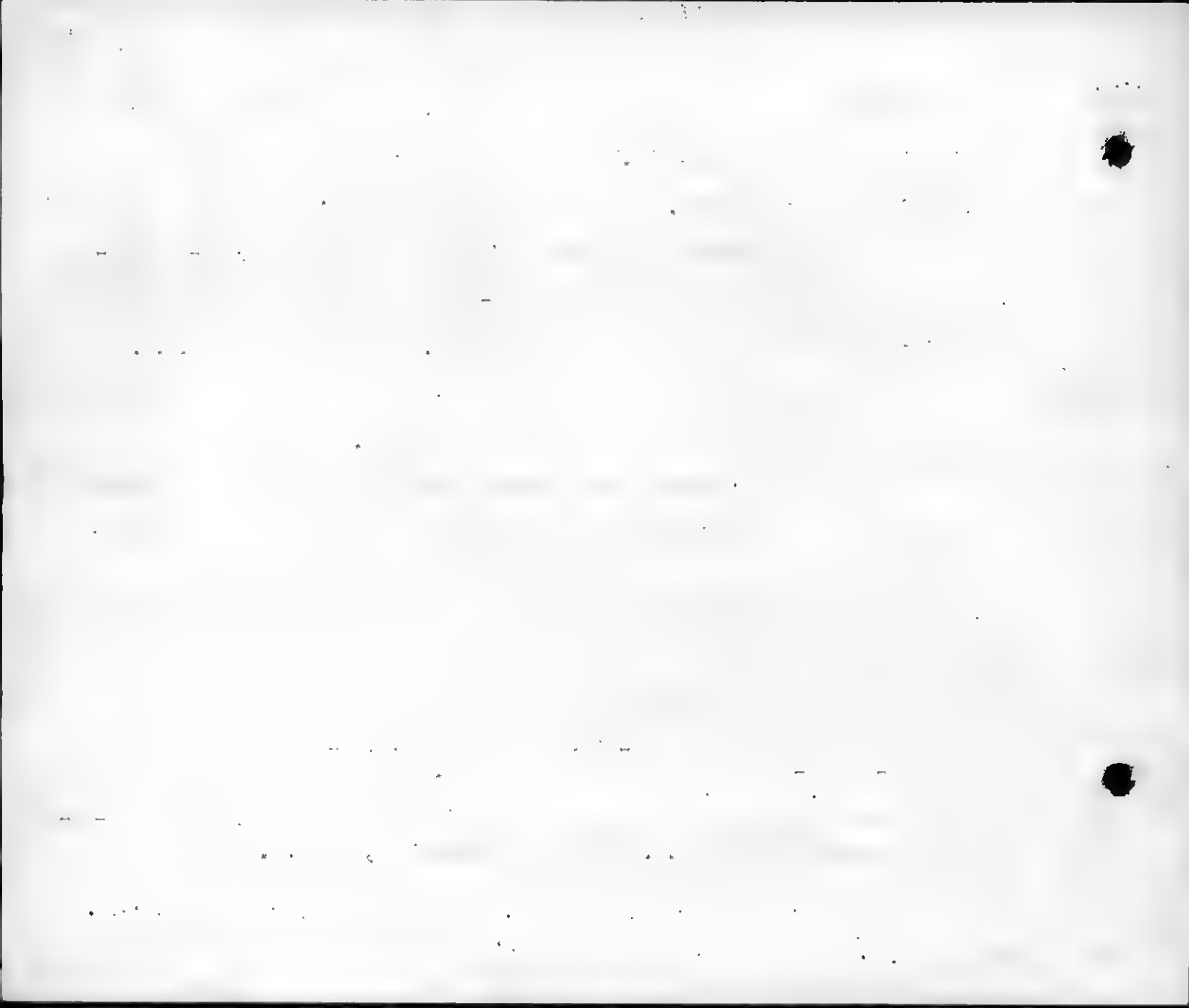
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore 03</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>						c. LENGTH OF STAY IN 1b <b>10mths.13days</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH							
First <b>Elizabeth</b> Middle <b>Purvis</b> Last <b>Sisco</b>						Month <b>5</b> Day <b>24</b> Year <b>1959</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-5-1864</b>		9. AGE (In years last birthday) yrs. <b>94</b>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Oliver Purvis</b>						14. MOTHER'S MAIDEN NAME <b>Rachel ?</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>Hospital records.</b>		INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 4 DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis with psychosis</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>7-11-</b> , <b>1959</b> , to <b>5-24-</b> , <b>1959</b> , that I last saw the deceased alive on <b>5-24-</b> , <b>1959</b> , and that death occurred at <b>6.47 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5-24-59</b> ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Sykesville, Maryland.</b> PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAK GROVE</b>				22d. LOCATION (City, town, or county) (State) <b>HAMMONTON, N.J.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Walter ...</b>						24. REC'D BY REGISTRAR DATE <b>MAY 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
LSM 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5494

Ite. 8 Filed 5/21/59 cap

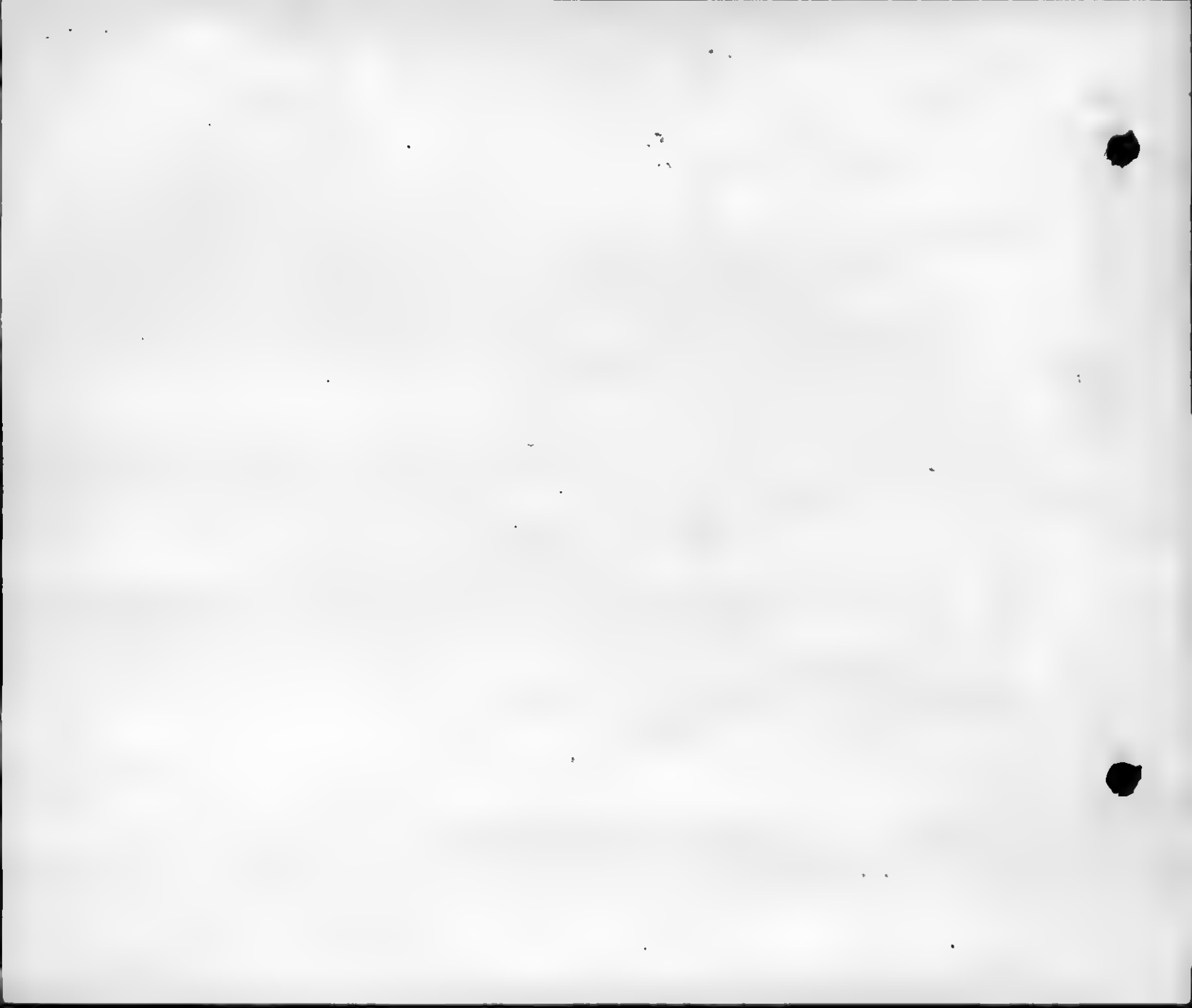
## CERTIFICATE OF DEATH

05483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster (Rural) 25717</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>L</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER - F - SMITH</u>		4. DATE OF DEATH <u>May 14 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 19 - 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>720</u>	
17. INFORMANT <u>Miss Wm. Smith Westminster, Md</u>		Address <u>Westminster, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>352 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1934</u> to <u>May 15 1959</u> , that I last saw the deceased alive on <u>May 14 1959</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u> DATE SIGNED <u>5/15/59</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield</u>		ADDRESS <u>Hampstead, Md</u> DATE SIGNED <u>5/15/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 5/16/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster to Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin L. Sifton</u>		ADDRESS <u>Hampstead</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

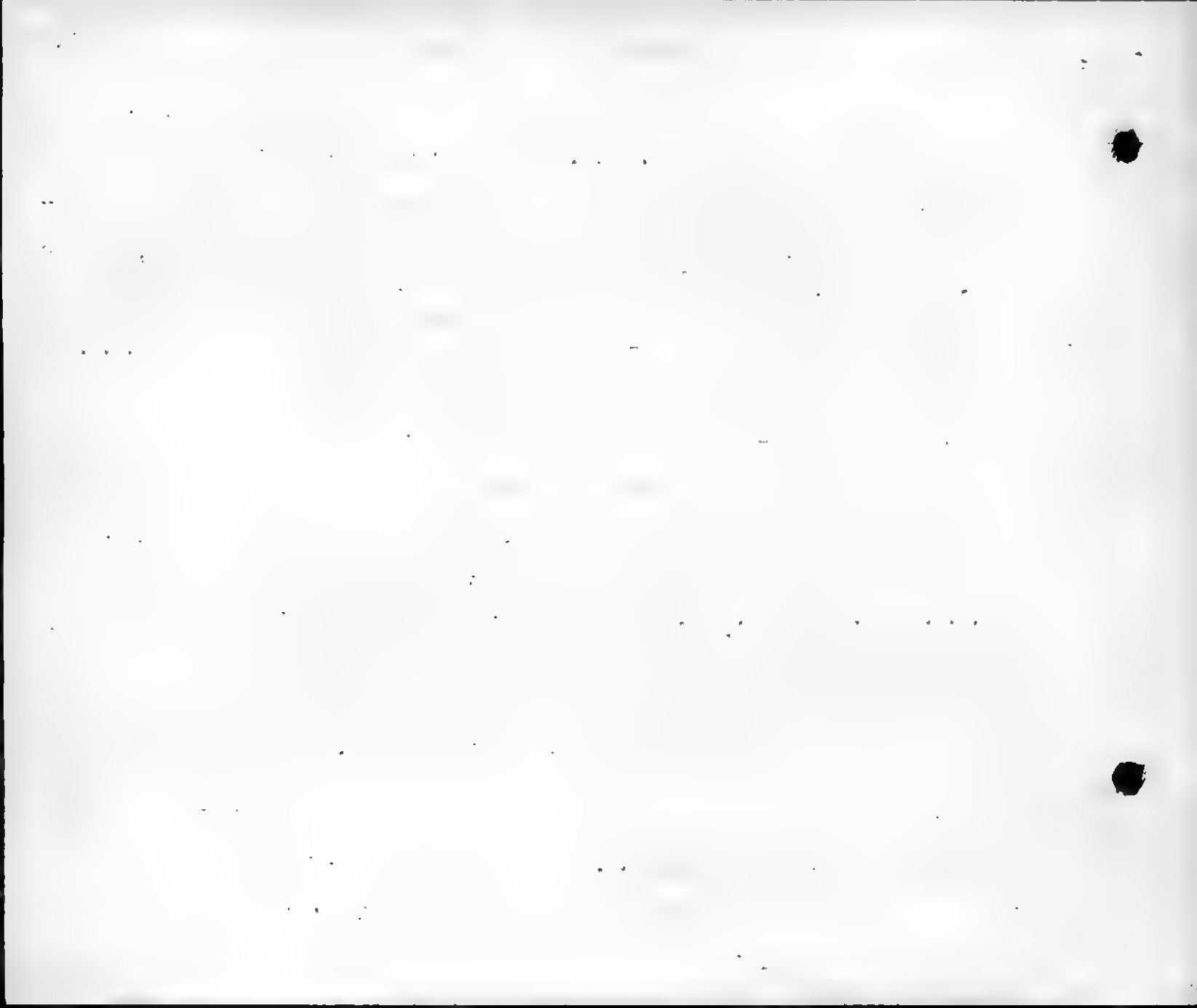
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5495 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6yrs.10mos.5days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Mount Savage R#1</b> <b>01X</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>None</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Edward</b> Last <b>Snyder</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>74</b> Days <b>14</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>74</b> Days <b>14</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Snyder</b>	
14. MOTHER'S MAIDEN NAME <b>Ellaza Wasson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>	
16. SOCIAL SECURITY NO <b>-</b>		INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 7, 19 55</b> to <b>May 14, 19 59</b> that I last saw the deceased alive on <b>May 13, 19 59</b> , and that death occurred at <b>4:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital</b> <b>5/14/59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 16, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed</b>	22d. LOCATION (City, town, or county) (State) <b>Knopville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Fester</b>		24a. REC'D BY REGISTRAR <b>Elva D. Fester md.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5496

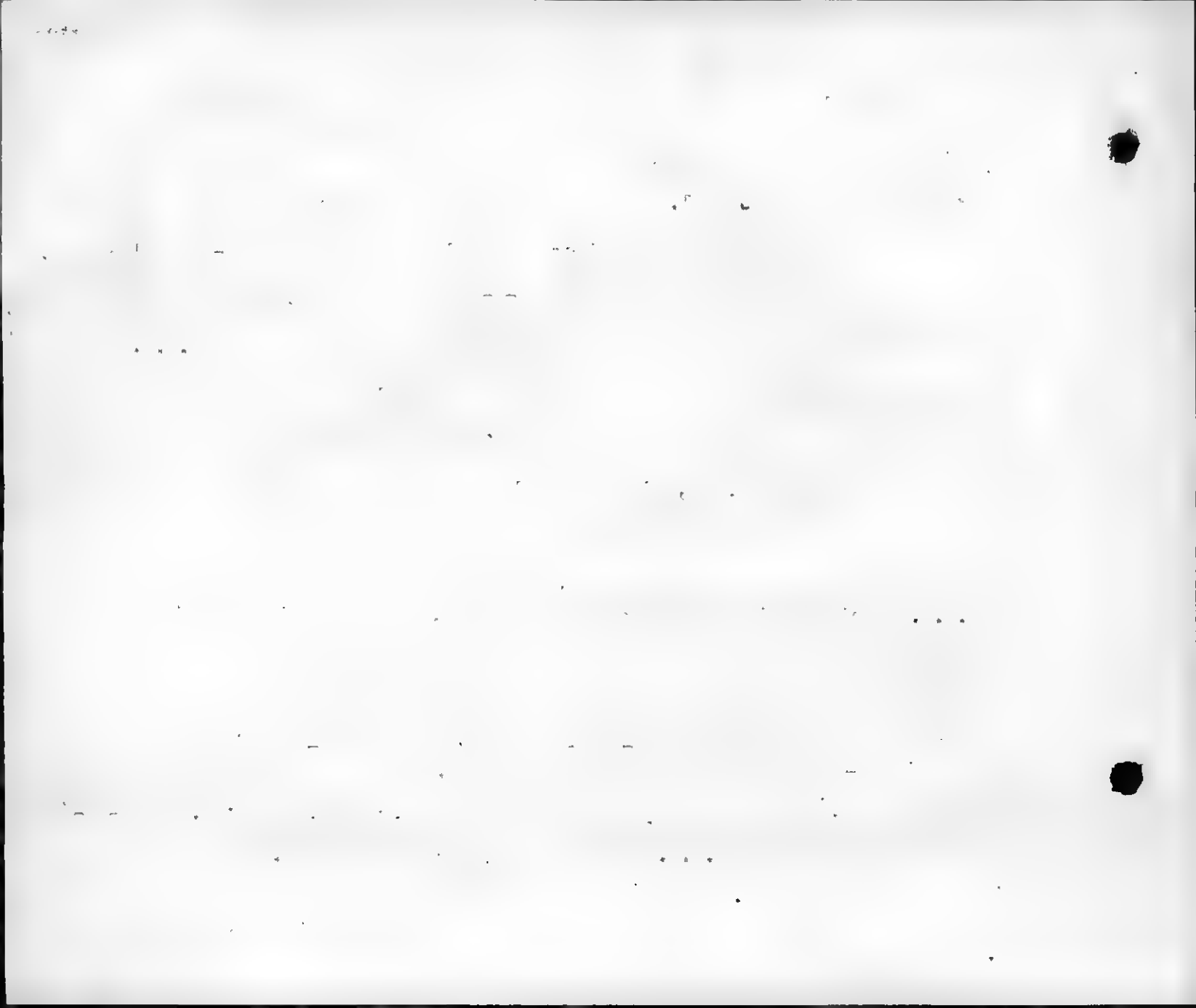
CERTIFICATE OF DEATH

05485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>23 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 30</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6</b> d. STREET ADDRESS <b>3803 Woodlea Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Mariner</b> Last <b>Snyder</b>		4. DATE OF DEATH Month <b>5-</b> Day <b>31</b> - Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-1896</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>31</b> Hours <b>19</b> Min. <b>59</b>	11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yeast maker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Medora ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Informant</b> Address <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia bilateral</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5- 8 - 1959</b> , to <b>5- 31 - 1959</b> , that I last saw the deceased alive on <b>5- 31 - 1959</b> , and that death occurred at <b>4:36 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital.</b> DATE SIGNED <b>5-31-59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>6/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	22d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Buck</b> ADDRESS <b>5305 Hartford</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

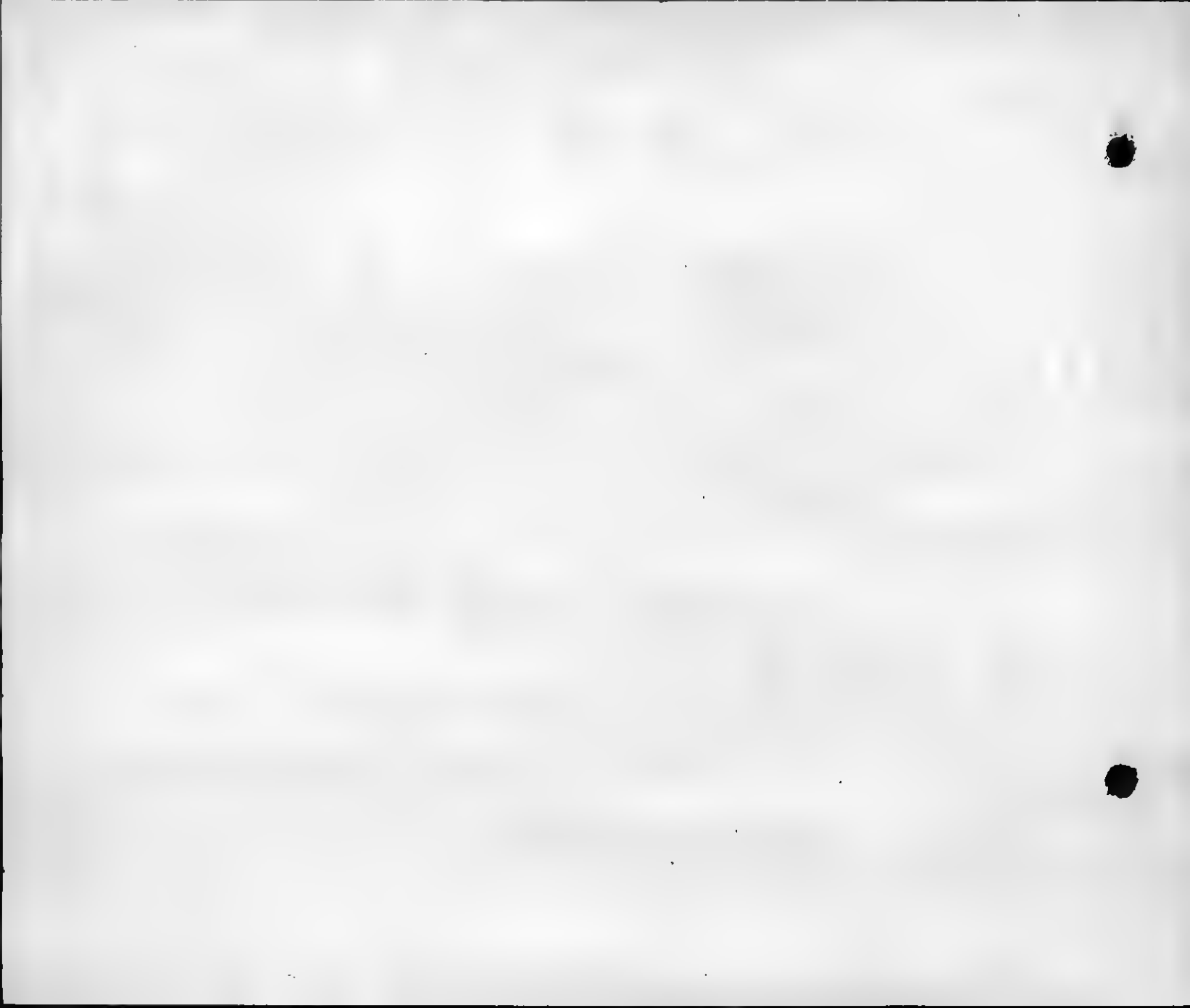


## 5497 CERTIFICATE OF DEATH

Reg. Dist. No.

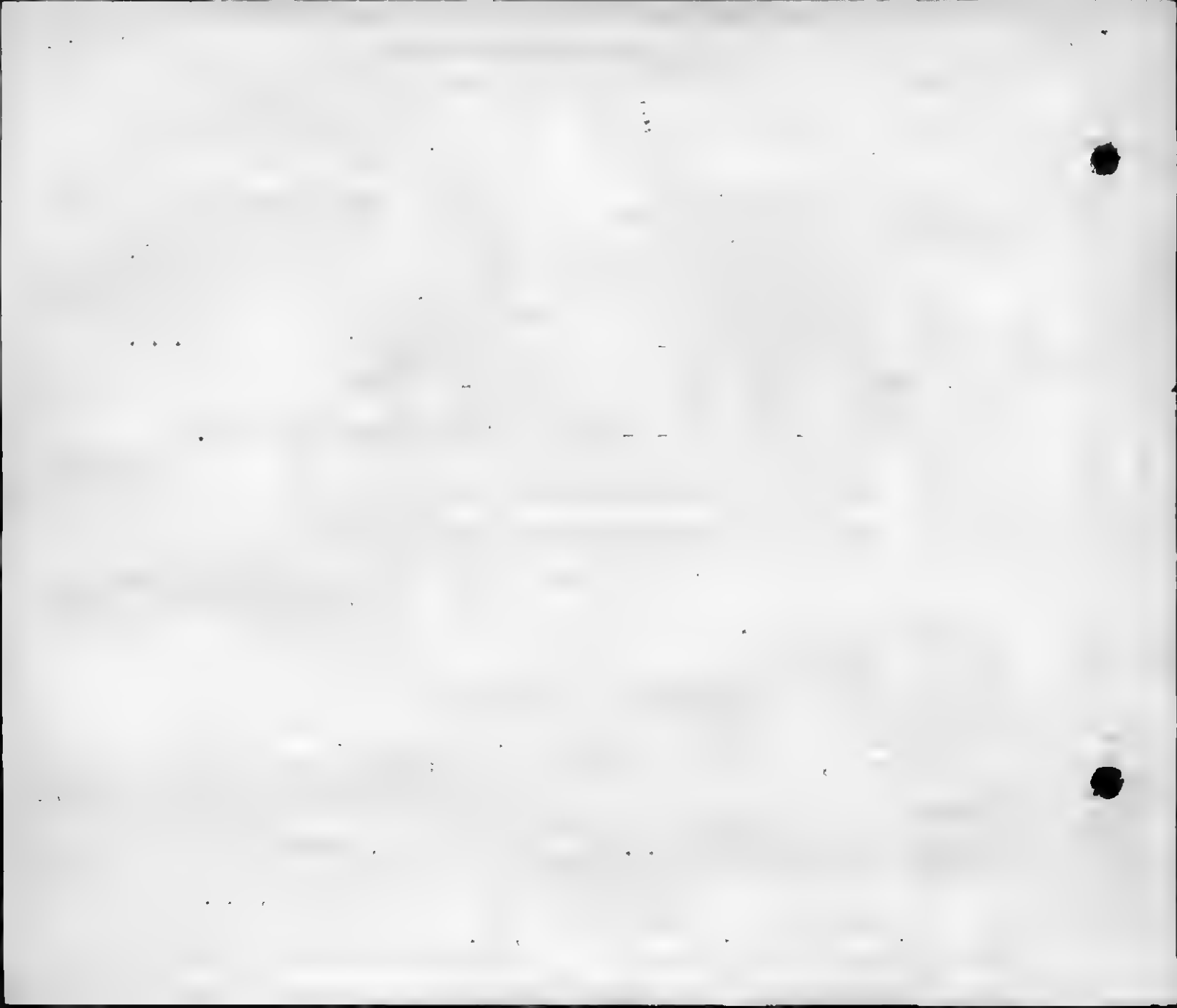
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>		d. STREET ADDRESS <u>MAIN ST</u>	
3. NAME OF DECEASED (Type or print) <u>LOUIS EZRA STAUFFER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 4 - 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRUGGIST</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EZRA STAUFFER</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE SLINGHUFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-3125</u>	
17. INFORMANT <u>GRACE LYNN UNION BRIDGE MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial changes</u> (c) <u>Chronic myocarditis</u> <u>pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-2-</u> 19 <u>59</u> to <u>5-31-</u> 19 <u>59</u> that I last saw the deceased alive on <u>5-31-</u> 19 <u>59</u> and that death occurred at <u>3:15</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Legg</u>		ADDRESS (Street, city or town, state) <u>Union Bridge, Md 21784</u>	
PHYSICIAN'S NAME (Type) <u>T. H. LEGG MD</u>		DATE SIGNED <u>5-31-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PIPECREEK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Q. D. Hartwick Union Bridge Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
DATE <u>JUN 3 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL CERTIFICATION

VS A15 (4)  
ISM 9/55



5442

## CERTIFICATE OF DEATH

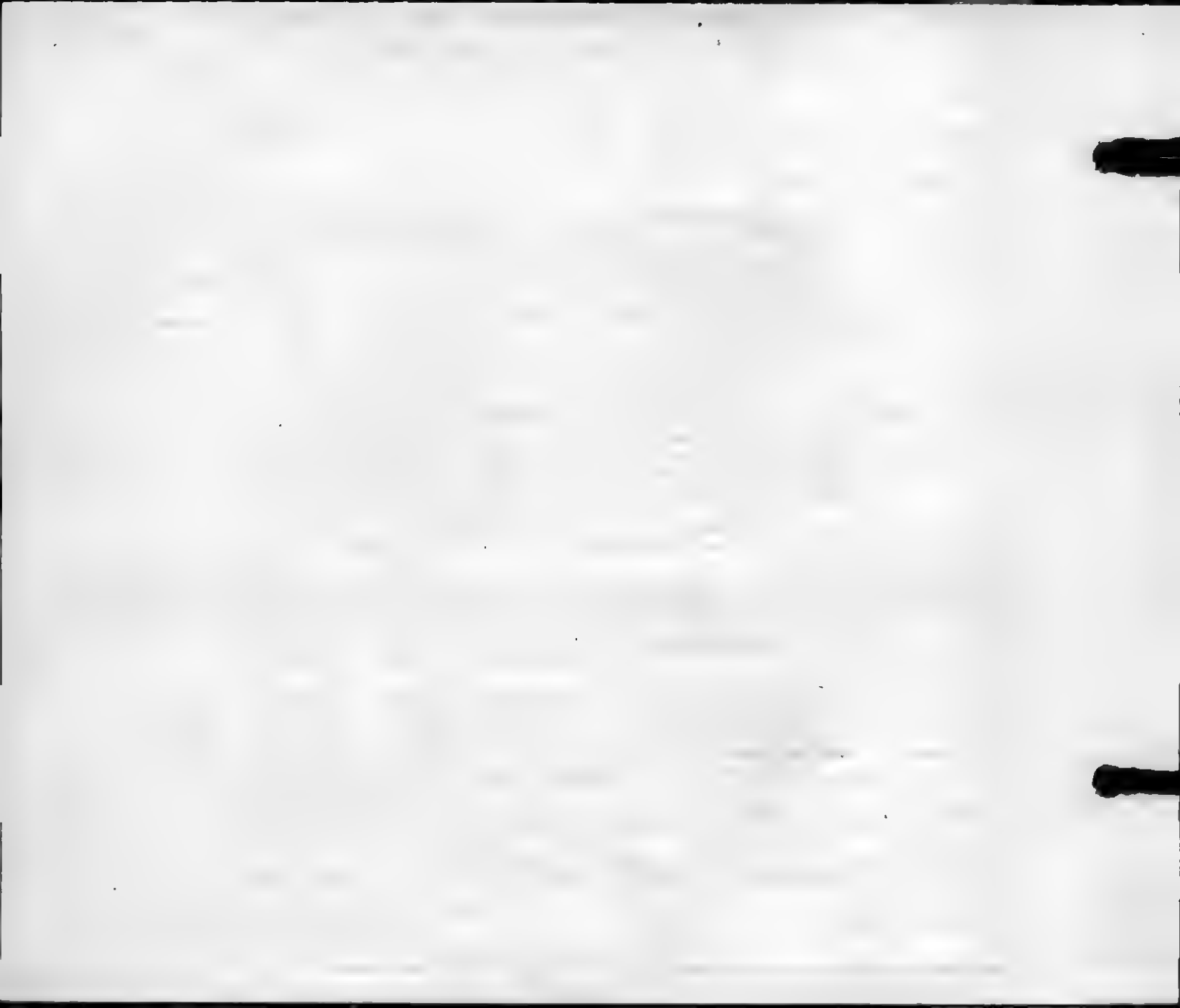
Reg. Dist. No.

05488

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>410 E. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN WINFIELD STONESIFER</u>		4. DATE OF DEATH <u>MAY 10 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 18, 1866</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter and Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AUGUSTUS STONESIFER</u>		14. MOTHER'S MAIDEN NAME <u>SAVILLA SNYDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Heland L. Pool, 410 E. Main St, Westminister, Md.</u>	
17. INFORMANT <u>Mr. Heland L. Pool, 410 E. Main St, Westminister, Md.</u>		18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 30, 1959</u> to <u>May 10, 1959</u> , that I last saw the deceased alive on <u>May 10, 1959</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.		ADDRESS (Street, city or town, state) <u>GREENSBORO, M.D.</u> DATE SIGNED <u>5/10/59</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES H. STONESIFER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rivers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural, Westminister, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. C. Myers, Jr. Westminister, Md.</u>		24. REC'D BY REGISTRAR <u>MAY 13 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician. If this certificate has been signed by the attending physician and completely filled in by the registrar, it may be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 5499 CERTIFICATE OF DEATH

05489

Reg. Dist. No.

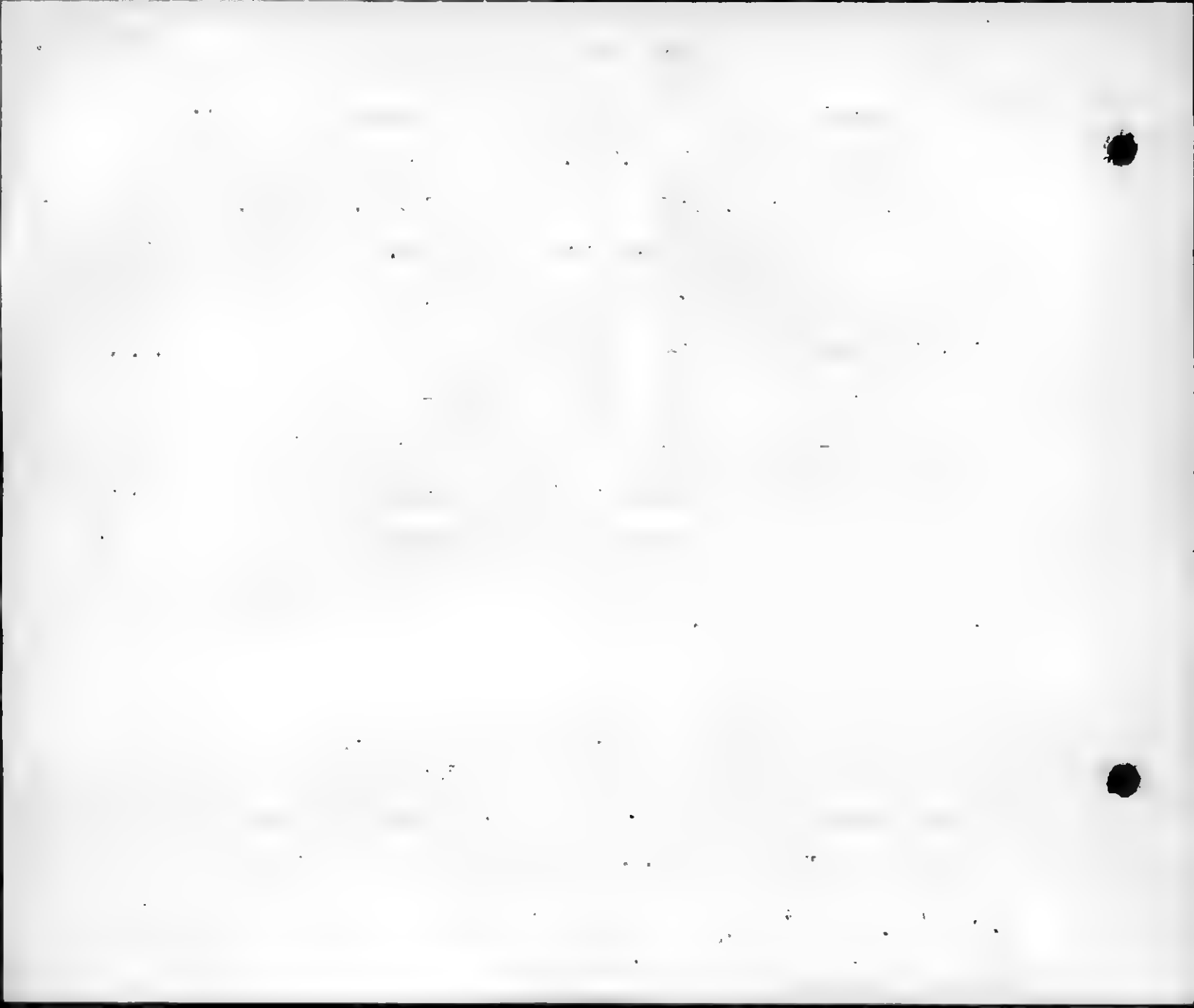
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
c. LENGTH OF STAY IN 1b <b>13yrs. 2mos. 17days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1950 W. Pratt St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Franklin</b> Last <b>Taylor, Sr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> , Year <b>19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Sara -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-5540</b>	
17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional melancholia.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>May 26, 1959</b> , that I last saw the deceased alive on <b>May 26, 1959</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>5/27/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-30-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. L. Schwaab</b>		24a. REC'D BY REGISTRAR <b>2101 Frederick Rd.</b>	
24b. REGISTRAR'S SIGNATURE <b>Orion S. Frank</b>		DATE <b>JUN 1 '59</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

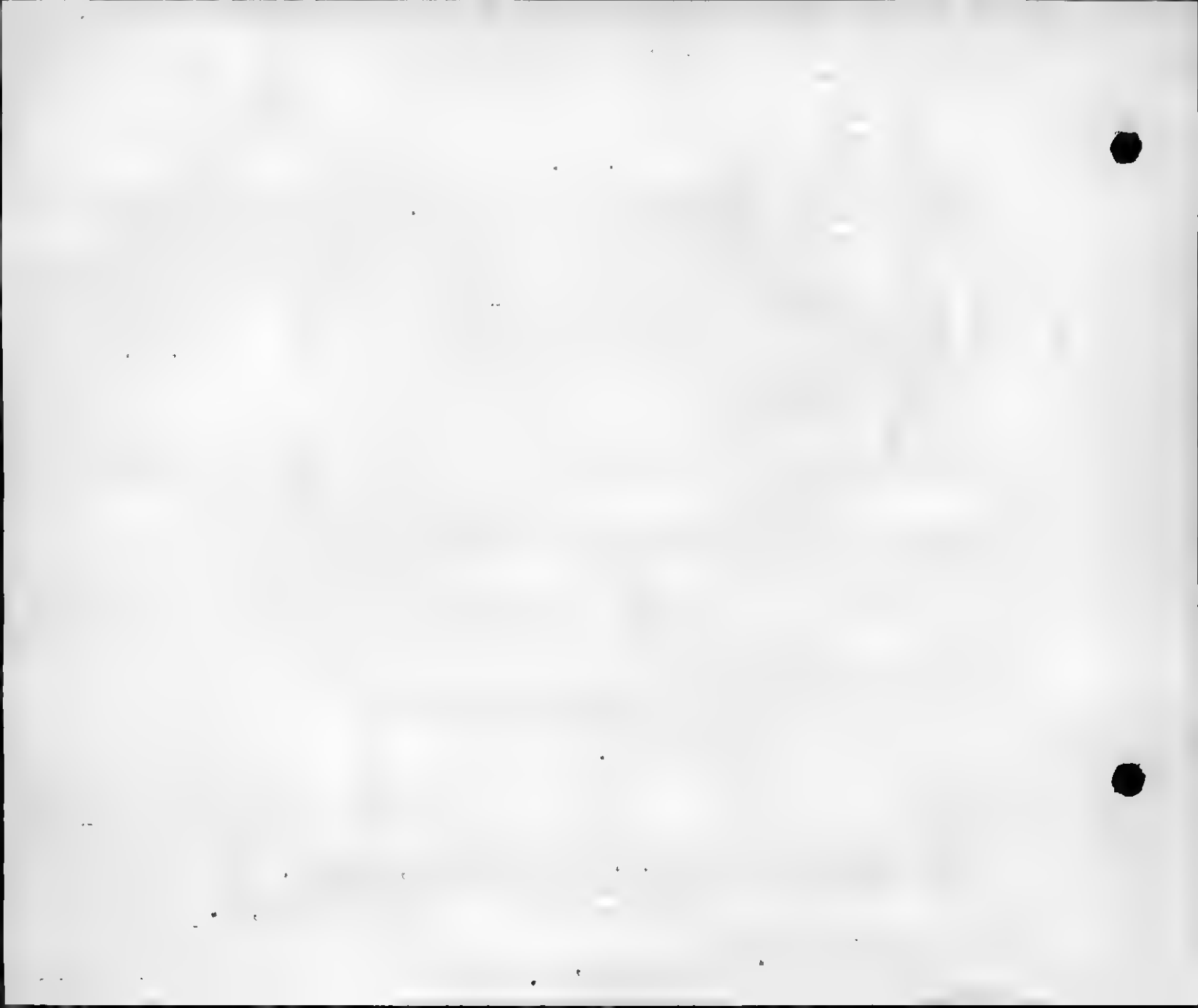
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5500 CERTIFICATE OF DEATH

Reg. Dist. No.

05490

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b> c. LENGTH OF STAY IN 1b <b>7 Yrs. 2 Mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>206 S. Gilmer Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Minnie Letitia WALKER</b>		4. DATE DEATH Month Day Year <b>May 23 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-19-72</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tayloring</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Israel Parsons</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann Kirby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-2336A</b>	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> <b>422.1</b> DUE TO (b) <b>Generalized arteriosclerosis</b> (Acute) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain syndrome associated with arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Days <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 20</b> , 19 <b>54</b> , to <b>May 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>59</b> , and that death occurred at <b>2-40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital</b> <b>5-23-59</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> <b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b> <b>4101 Edmondson Ave. B</b> <b>Baltimore 29, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



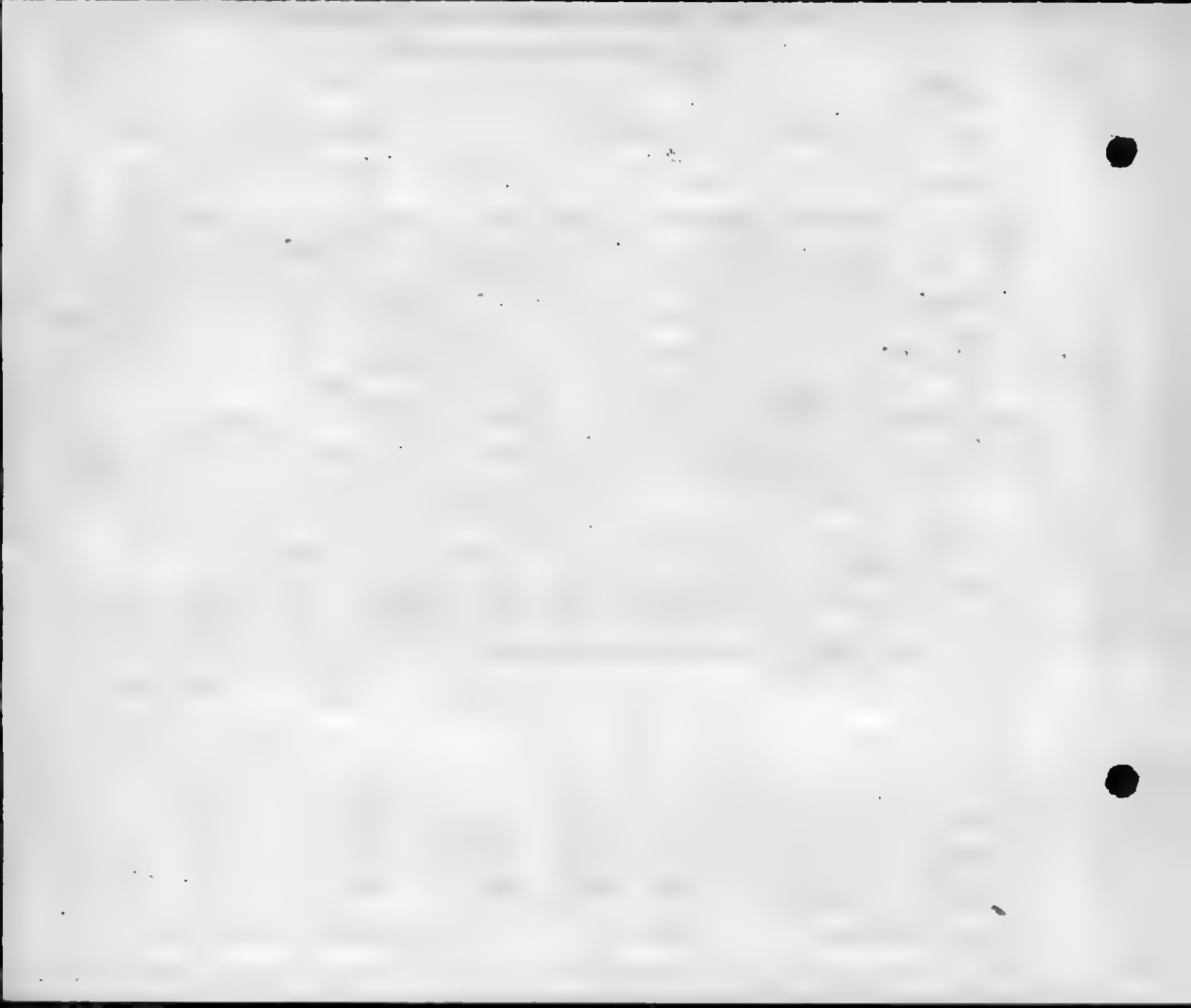
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5501 CERTIFICATE OF DEATH

05492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lundboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lundboro</u>	
c. LENGTH OF STAY IN 1b <u>30</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>F.</u> Last <u>WARNER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Feed</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Frank Warner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Houch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>720-09-6377</u>	
17. INFORMANT <u>Wm. B. F. Warner</u>		Address <u>Lundboro, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia (Renal Failure)</u> DUE TO <u>metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma Colon</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>6 Mo N</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>May 26</u> , 1959, that I last saw the deceased alive on <u>May 25</u> , 1959, and that death occurred at <u>8 A</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foard</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>		DATE SIGNED <u>5/26/59</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lundboro Carroll Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Foard</u>		24. REC'D BY REGISTRAR DATE <u>MAY 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Farnham</u>			



## 5502 CERTIFICATE OF DEATH

05493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>31yrs11mths23dys</b> (Canton) Baltimore <b>3401-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>S.</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>5-</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-16-1897</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>62</b>	11. IF UNDER 24 HRS Hours <b>62</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Williams</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kisner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Informant</b>	
17. ADDRESS <b>Sykesville, Md.</b>		18. HOSPITAL RECORDS <b>Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>Hypertensive heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. due to cerebral arteriosclerosis</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>March 7</b> 19 <b>55</b> , to <b>May 8</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 8</b> 19 <b>59</b> , and that death occurred at <b>10:28</b> A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		DATE SIGNED <b>5-10-59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>5/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hayes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

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1992-1993, 1993-1994, 1994-1995, 1995-1996, 1996-1997, 1997-1998, 1998-1999, 1999-2000, 2000-2001, 2001-2002, 2002-2003, 2003-2004, 2004-2005, 2005-2006, 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024, 2024-2025, 2025-2026, 2026-2027, 2027-2028, 2028-2029, 2029-2030, 2030-2031, 2031-2032, 2032-2033, 2033-2034, 2034-2035, 2035-2036, 2036-2037, 2037-2038, 2038-2039, 2039-2040, 2040-2041, 2041-2042, 2042-2043, 2043-2044, 2044-2045, 2045-2046, 2046-2047, 2047-2048, 2048-2049, 2049-2050, 2050-2051, 2051-2052, 2052-2053, 2053-2054, 2054-2055, 2055-2056, 2056-2057, 2057-2058, 2058-2059, 2059-2060, 2060-2061, 2061-2062, 2062-2063, 2063-2064, 2064-2065, 2065-2066, 2066-2067, 2067-2068, 2068-2069, 2069-2070, 2070-2071, 2071-2072, 2072-2073, 2073-2074, 2074-2075, 2075-2076, 2076-2077, 2077-2078, 2078-2079, 2079-2080, 2080-2081, 2081-2082, 2082-2083, 2083-2084, 2084-2085, 2085-2086, 2086-2087, 2087-2088, 2088-2089, 2089-2090, 2090-2091, 2091-2092, 2092-2093, 2093-2094, 2094-2095, 2095-2096, 2096-2097, 2097-2098, 2098-2099, 2099-2100, 2100-2101, 2101-2102, 2102-2103, 2103-2104, 2104-2105, 2105-2106, 2106-2107, 2107-2108, 2108-2109, 2109-2110, 2110-2111, 2111-2112, 2112-2113, 2113-2114, 2114-2115, 2115-2116, 2116-2117, 2117-2118, 2118-2119, 2119-2120, 2120-2121, 2121-2122, 2122-2123, 2123-2124, 2124-2125, 2125-2126, 2126-2127, 2127-2128, 2128-2129, 2129-2130, 2130-2131, 2131-2132, 2132-2133, 2133-2134, 2134-2135, 2135-2136, 2136-2137, 2137-2138, 2138-2139, 2139-2140, 2140-2141, 2141-2142, 2142-2143, 2143-2144, 2144-2145, 2145-2146, 2146-2147, 2147-2148, 2148-2149, 2149-2150, 2150-2151, 2151-2152, 2152-2153, 2153-2154, 2154-2155, 2155-2156, 2156-2157, 2157-2158, 2158-2159, 2159-2160, 2160-2161, 2161-2162, 2162-2163, 2163-2164, 2164-2165, 2165-2166, 2166-2167, 2167-2168, 2168-2169, 2169-2170, 2170-2171, 2171-2172, 2172-2173, 2173-2174, 2174-2175, 2175-2176, 2176-2177, 2177-2178, 2178-2179, 2179-2180, 2180-2181, 2181-2182, 2182-2183, 2183-2184, 2184-2185, 2185-2186, 2186-2187, 2187-2188, 2188-2189, 2189-2190, 2190-2191, 2191-2192, 2192-2193, 2193-2194, 2194-2195, 2195-2196, 2196-2197, 2197-2198, 2198-2199, 2199-2200, 2200-2201, 2201-2202, 2202-2203, 2203-2204, 2204-2205, 2205-2206, 2206-2207, 2207-2208, 2208-2209, 2209-2210, 2210-2211, 2211-2212, 2212-2213, 2213-2214, 2214-2215, 2215-2216, 2216-2217, 2217-2218, 2218-2219, 2219-2220, 2220-2221, 2221-2222, 2222-2223, 2223-2224, 2224-2225, 2225-2226, 2226-2227, 2227-2228, 2228-2229, 2229-2230, 2230-2231, 2231-2232, 2232-2233, 2233-2234, 2234-2235, 2235-2236, 2236-2237, 2237-2238, 2238-2239, 2239-2240, 2240-2241, 2241-2242, 2242-2243, 2243-2244, 2244-2245, 2245-2246, 2246-2247, 2247-2248, 2248-2249, 2249-2250, 2250-2251, 2251-2252, 2252-2253, 2253-2254, 2254-2255, 2255-2256, 2256-2257, 2257-2258, 2258-2259, 2259-2260, 2260-2261, 2261-2262, 2262-2263, 2263-2264, 2264-2265, 2265-2266, 2266-2267, 2267-2268, 2268-2269, 2269-2270, 2270-2271, 2271-2272, 2272-2273, 2273-2274, 2274-2275, 2275-2276, 2276-2277, 2277-2278, 2278-2279, 2279-2280, 2280-2281, 2281-2282, 2282-2283, 2283-2284, 2284-2285, 2285-2286, 2286-2287, 2287-2288, 2288-2289, 2289-2290, 2290-2291, 2291-2292, 2292-2293, 2293-2294, 2294-2295, 2295-2296, 2296-2297, 2297-2298, 2298-2299, 2299-2300, 2300-2301, 2301-2302, 2302-2303, 2303-2304, 2304-2305, 2305-2306, 2306-2307, 2307-2308, 2308-2309, 2309-2310, 2310-2311, 2311-2312, 2312-2313, 2313-2314, 2314-2315, 2315-2316, 2316-2317, 2317-2318, 2318-2319, 2319-2320, 2320-2321, 2321-2322, 2322-2323, 2323-2324, 2324-2325, 2325-2326, 2326-2327, 2327-2328, 2328-2329, 2329-2330, 2330-2331, 2331-2332, 2332-2333, 2333-2334, 2334-2335, 2335-2336, 2336-2337, 2337-2338, 2338-2339, 2339-2340, 2340-2341, 2341-2342, 2342-2343, 2343-2344, 2344-2345, 2345-2346, 2346-2347, 2347-2348, 2348-2349, 2349-2350, 2350-2351, 2351-2352, 2352-2353, 2353-2354, 2354-2355, 2355-2356, 2356-2357, 2357-2358, 2358-2359, 2359-2360, 2360-2361, 2361-2362, 2362-2363, 2363-2364, 23

$$C_{\text{eff}} = \frac{C_{\text{eff}}^{\text{eff}}}{C_{\text{eff}}^{\text{eff}} + C_{\text{eff}}^{\text{eff}}}$$

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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5443

## CERTIFICATE OF DEATH

05494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>37 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>53 Chase St.</u>				d. STREET ADDRESS <u>53 Chase St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>WISE</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 20, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Ridgely</u>				14. MOTHER'S MAIDEN NAME <u>Susan Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs R. G. Horng</u> Address <u>53 Chase St. Westminster Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5-1</u> , 19 <u>59</u> , to <u>5-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-5</u> , 19 <u>59</u> , and that death occurred at <u>3:30</u> A. M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>James T Marsh</u> M.D. <u>105 E MAIN ST</u>				<u>5-9-59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>				<u>Westminster Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 11, 1959</u>		<u>London Park Cemetery</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers Jr</u> ADDRESS <u>Westminster Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>MAY 11 '59</u>		<u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

